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Part I

SALUS POPULI SUPREMA LEX ESTO

*"The welfare of the people shall be the supreme law."*



ROBIN CARNAHAN  
SECRETARY OF STATE

# MISSOURI REGISTER

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Register Filing Deadlines	Register Publication Date	Code Publication Date	Code Effective Date
October 1, 2010	November 1, 2010	November 30, 2010	December 30, 2010
October 15, 2010	November 15, 2010	November 30, 2010	December 30, 2010
November 1, 2010	December 1, 2010	December 31, 2010	January 30, 2011
November 15, 2010	December 15, 2010	December 31, 2010	January 30, 2011
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May 16, 2011	June 15, 2011	June 30, 2011	July 30, 2011
June 1, 2011	July 1, 2011	July 31, 2011	August 30, 2011
June 15, 2011	July 15, 2011	July 31, 2011	August 30, 2011

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at <http://www.sos.mo.gov/adrules/pubsched.asp>

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**RULES**—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 28, *Missouri Register*, page 27. The approved short form of citation is 28 MoReg 27.

The rules are codified in the *Code of State Regulations* in this system—

Title	Code of State Regulations	Division	Chapter	Rule
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

**RSMo**—The most recent version of the statute containing the section number and the date.



**R**ules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

**R**ules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

**A**ll emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

*employees will suffer financial harm in that they will not be able to offset certain medical expenses and health care premiums under the plan. A proposed amendment which covers the same material is published in this issue of the Missouri Register. This emergency amendment limits its scope to the circumstances creating the emergency and complies with the protections extended by the Missouri and United States Constitutions. The Office of Administration believes this emergency amendment to be fair to all interested persons and parties under the circumstances. This emergency amendment was filed December 21, 2010, becomes effective January 1, 2011, and expires June 29, 2011.*

(2) The commissioner of administration shall maintain the cafeteria plan, the dependent care assistance plan, and the flexible medical benefits plan, in written form, denominated as the Missouri State Employees' Cafeteria Plan [(Appendix A), the Missouri State Employees' Dependent Care Assistance Plan (Appendix B) and the Missouri State Employees' Flexible Medical Benefits Plan (Appendix C), which are included herein, for Plan Year 1998 and years following] Document attached as Appendix A.

**Title 1—OFFICE OF ADMINISTRATION  
Division 10—Commissioner of Administration  
Chapter 15—Cafeteria Plan**

**EMERGENCY AMENDMENT**

**1 CSR 10-15.010 Cafeteria Plan.** The commissioner is amending Section (2) and deleting Appendices A, B, and C and replacing with Appendix A Cafeteria Plan for the Employees of the State of Missouri Plan Document.

*PURPOSE: This amendment is being filed to comply with federal regulations of Section 125 of the IRS Code.*

*EMERGENCY STATEMENT: This emergency amendment is necessary to preserve the compelling governmental interest of amending the state of Missouri's Cafeteria Plan to comply with changes to Section 125 of the IRS Code and regulations resulting from the passage of the Patient Protection and Affordable Care Act in 2010. After learning that the 2010 changes in federal law would affect the plan, the Office of Administration, with guidance from the claims administrator for the plan, began reviewing and extensively revising the plan, completing the final revisions on December 15, 2010. This amendment must become effective by January 1, 2011, so that the 2011 plan can be implemented on that date, which is the beginning of the new plan period. Without this emergency amendment, the 2011 plan would not be available to approximately seventy-two thousand (72,000) state and political subdivision employees. If the plan is not amended,*

[APPENDIX A  
MISSOURI STATE EMPLOYEES' CAFETERIA PLAN

*The State of Missouri through the Office of Administration hereby amends and restates the Missouri State Employees' Cafeteria Plan (hereinafter called the MSECP) effective January 1, 2009. The provisions of the MSECP, as set forth in this document and the attendant documents for the Missouri State Employees' Dependent Care Assistance Plan (Appendix B, hereinafter called the MSEDCA) and the Missouri State Employees' Flexible Medical Benefits Plan (Appendix C, hereinafter called the MSEFMBP), shall be applicable to each employee of the State of Missouri unless he/she elects not to participate in the MSECP beginning with Plan Year 2009.*

ARTICLE ONE  
DEFINITIONS

*1.01 "Account" means the account(s) maintained under the MSECP by the Plan Administrator to which allocations of employer contributions are made for each participant as required by the MSECP and from which payments, as permitted by the MSECP, shall be paid.*

*1.02 "Employee" means any person employed by the employer.*

*1.03 "Employer" means the State of Missouri including any agency, or department of the State of Missouri other than the University of Missouri and Southeast Missouri State University.*

*1.04 "Office of Administration" means the Office of Administration of the State of Missouri.*

*1.05 "Participant" means any employee who has not waived coverage and is participating in the MSECP.*

*1.06 "Plan Administrator" means the Office of Administration or its duly appointed designee to administer the MSECP.*

*1.07 "Plan Year" means the calendar year.*

*1.08 "Spouse or Dependent" means the spouse or dependent of a participant within the meaning of Section 125 and 152 of the Internal Revenue Code.*

*1.09 "FMLA" means the Family and Medical Leave Act of 1993, as amended.*

*1.10 "Waive coverage" means to formally opt-out of participation in the MSECP sections 4.01(a), 4.01(b), 4.01(c), 4.01(d), 4.01(e), and/or 4.01(g) in writing or online.*

ARTICLE TWO  
STATEMENT OF PURPOSE

*2.01 This Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code, as amended, and is to be interpreted in a manner consistent with the requirements of Section 125. The purpose of the MSECP is to provide to participants the tax savings opportunities permissible under Section 125 of the Internal Revenue Code.*

*2.02 The MSECP will be nondiscriminatory, as such term is used in Section 125 of the Internal Revenue Code, and the employer will take such action as may be necessary to maintain the MSECP as nondiscriminatory under said code section.*

ARTICLE THREE  
ELIGIBILITY AND PARTICIPATION

*3.01 The MSECP does not apply to any individual who terminated employment with the employer prior to the effective date of this amended and restated MSECP (January 1, 2009) unless such individual becomes reemployed by the employer on or after such effective date.*

*3.02 Any employee who is on the payroll of the employer as of the effective date is eligible to become a participant on the effective date. Any employee, except any employee subject to the provisions of the MSECP, section 3.03, who chooses not to become a participant at the beginning of each Plan Year will not again become eligible for participation in the MSECP until the beginning of the next Plan Year, except as provided under the MSECP, section 3.09.*

*3.03 Any person who becomes an employee after the effective date shall be automatically enrolled unless waiving coverage in the MSECP within thirty-one (31) days from the date of employment. Such employee shall become a participant on the first day of the first full month coincident with or next following the date of employment.*

*3.04 Subject to the provisions of the MSECP, section 3.05, an eligible employee shall automatically become a participant of 4.01(a), 4.01(d), 4.01(e), and 4.01(g) for any and each Plan Year unless waiving coverage of the specific plan, and agree to and authorize the reduction of the participant's compensation by a permissible amount for credit to the participant's account as maintained by the Plan Administrator. For purposes of the first sentence of this paragraph, the term "permissible amount"*

*(unless and until subsequently changed by appropriate action of the Office of Administration and notice of such change is provided to all participants) means an amount(s) determined by the participant which is (are):*

*(a) not more than the expected total cost or premium during the Plan Year in the case of the State-Sponsored Medical Insurance benefit described in the MSECP, section 4.01(a);*

*(b) not more than five thousand dollars (\$5,000) in the case of the Flexible Medical Benefits benefit described in the MSECP, section 4.01(b);*

*(c) not more than five thousand dollars (\$5,000) in the case of the Dependent Care Assistance benefit described in the MSECP, section 4.01(c);*

*(d) not more than the expected total cost or premium during the Plan Year in the case of the State-Sponsored Dental Insurance benefit described in the MSECP, section 4.01(d);*

*(e) not more than the expected total cost or premium during the Plan Year in the case of the State-Sponsored Vision Care Insurance benefit described in the MSECP, section 4.01(e).*

*(f) not more than the expected sum of the total cost or premium during the Plan Year in the case of any other product or products eligible under Section 125 of Title 26 of the United States Code, as described in MSECP section 4.01(g).*

*In the event of any change in the permissible amount, the resulting new permissible amount must be nondiscriminatory (as defined in Section 125 of the Internal Revenue Code) in its application to participants. In the case of the insurance benefits or products described in the MSECP, sections 4.01(a), 4.01(d), 4.01(e), and 4.01(g) the permissible amount must be consistent with the actual rate in effect at the start of the coverage period or it will automatically be changed to reflect the actual rate in effect at the start of the coverage period.*

*3.05 Except as otherwise provided in the MSECP, section 3.03, the waiving of elections and flexible benefit authorizations required by the provision of the MSECP section 3.04 must be submitted to the Plan Administrator by a date established by the Plan Administrator which shall be prior to the first day of the applicable Plan Year. Any employee who becomes a participant pursuant to the MSECP, section 3.03 shall be allowed to submit the required waiver request with the Plan Administrator no later than thirty-one (31) days from the date of employment in order to waive participation from the program.*

*3.06 Any employee who fails to make an election when first eligible under section 3.04 or 3.05 shall be deemed to have elected to reduce his or her cash compensation in an amount equal to the total of the amounts for coverage in effect on the first day of participation of the applicable Plan Year described in sections 4.01(a), 4.01(d), 4.01(e), and 4.01(g) and to have such amounts pay for coverage described in sections 4.01(a), 4.01(d), 4.01(e), and 4.01(g) to the extent he or she has elected such coverage. Further, any such employee who fails to make an election under section 3.04 or 3.05 shall be deemed to have elected to not receive any benefits under the coverage described in sections 4.01(b) and 4.01(c) and to receive the balance of his or her entire compensation in cash.*

*3.07 Any employee duly enrolled and participating in one or more of the insurance plans described in the MSECP, sections 4.01(a), 4.01(d), 4.01(e), or 4.01(g) shall be considered to have submitted the required authorization to continue participation in the same plan(s) for the subsequent Plan Year at an amount equal to the total expected annual cost or premium based on the rate in effect as of January 1 of that subsequent Plan Year. A participant who does not wish to continue an insurance plan under the Cafeteria Plan for a subsequent Plan Year must so specify on the appropriate election form or in an alternate prescribed manner prior to the start of the subsequent Plan Year.*

*3.08 Any employee who elects pursuant to an authorization under section 3.05 of this Plan an amount under the Flexible Medical Benefits described in the MSECP, section 4.01(b) or the Dependent Care Assistance plan described in the MSECP, section 4.01(c) for any Plan Year shall be deemed to have also made an election to receive benefits under sections 4.01(a), 4.01(d), 4.01(e), and 4.01(g) to the extent the participant's share of premiums (if any) for any benefits under sections 4.01(a), 4.01(d), 4.01(e), and 4.01(g).*

### **3.09 Permitted Election Changes.**

*(a) Following the commencement of any Plan Year for which an employee participates in the MSECP, the authorization filed with the Plan Administrator for such Plan Year may neither be changed nor revoked except as provided in this section. An employee may revoke an election during a period of coverage and make a new election for the remainder of the relevant coverage period only as provided in paragraphs (b) through (h) of this section. Such revocation and new election must be made within sixty (60) days of an event described in (b) through (g) of this section and is made on account of and corresponds to the event.*

*(b) Special enrollment rights. An employee may revoke an election for a benefit described under Article Four, section 4.01(a), 4.01(d), or 4.01(e) and make a new election that corresponds with the special enrollment rights provided in Internal Revenue Code Section 9801(f) (HIPAA), whether or not the change in election is permitted under paragraph (c) of this section.*

*(c) Changes in status.*

*1. An employee may revoke an election and make a new election for the remaining portion of the period if, under the facts and circumstances—*

*(i) A change in status occurs; and*

*(ii) The election change satisfies the consistency requirement in paragraph (c)(3) of this section.*

*2. Change in status events. The following events are changes in status for purposes of this paragraph (c)—*

*(i) Legal marital status. Events that change an employee's legal marital status, including marriage, death of spouse, divorce, legal separation, or annulment;*

(ii) *Number of dependents.* Events that change an employee's number of dependents (as defined in Internal Revenue Code Section 152), including birth, adoption, placement for adoption (as defined in regulations under Internal Revenue Code Section 9801), or death of a dependent, or in the case of Dependent Care, a change in the number of qualifying individuals as defined in the Internal Revenue Code Section 21(b)(1);

(iii) *Employment status.* Any of the following events that change the employment status of the employee, spouse, or dependent is considered a change in status. A termination, commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence of more than thirty (30) days, change in worksite, or any other employment status change that affects eligibility under this plan or employee benefit plan of the employer of the spouse or dependent;

(iv) *Dependent satisfies or ceases to satisfy the requirements for unmarried dependents.* An event that causes an employee's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstances as provided in the accident or health plan under which the employee receives coverage; and

(v) *Residence.* A change in the place of residence of the employee, spouse, or dependent.

### 3. Consistency rule—

(i) *General rule.* An employee's revocation of a Cafeteria Plan election during a period of coverage and a new election for the remaining portion of the period (referred to as an "election change") is consistent with a change in status if, and only if—

(A) The change in status results in the employee, spouse, or dependent gaining or losing eligibility for coverage under either the Cafeteria Plan or a plan of the spouse's or dependent's employer; and

(B) The election change corresponds with that gain or loss of coverage.

(ii) If the change in status is the employee's divorce, annulment or legal separation from a spouse, the death of a spouse or dependent, or a dependent ceasing to satisfy the eligibility requirements for coverage, an employee's election under the cafeteria plan to cancel accident or health insurance coverage for any individual other than the spouse involved in the divorce, annulment, or legal separation, the deceased spouse or dependent, or the dependent that ceased to satisfy the eligibility requirements for coverage, respectively, fails to correspond with that change in status. Thus, if a dependent dies or ceases to satisfy the eligibility requirements for coverage, the employee's election to cancel accident or health coverage for any other dependent, for the employee, or for the employee's spouse fails to correspond with that change in status.

In addition, if an employee, spouse, or dependent gains eligibility for coverage under a plan provided by the employer of the spouse or dependent as a result of a change in marital status or a change in employment status, the employee may cease or decrease coverage for that individual only if coverage for that individual becomes applicable or is increased under that employer's plan.

(iii) A change in status results in an employee, spouse, or dependent gaining (or losing) eligibility for coverage under a plan only if the individual becomes eligible (or ineligible) to participate in the plan. An individual is considered to gain or lose eligibility for coverage if the individual becomes eligible (or ineligible) for a particular package option under a plan (e.g., a change in status results in an individual becoming eligible for a managed care option or an indemnity option). If, as a result of a change in status, the individual gains eligibility for elective coverage under a plan of the spouse's or dependent's employer, the consistency rule of this paragraph (c)(3)(i) is satisfied only if the individual elects the coverage under the spouse's or dependent's employer.

(iv) *Exception for COBRA.* Notwithstanding paragraph (c)(3)(i) of this section, if the employee, spouse, or dependent becomes eligible for continuation coverage under any of the employer's health plans described in sections 4.01(a), 4.01(d), 4.01(e), or 4.01(g) as provided under COBRA or any similar state law, the employee may increase payments under the Cafeteria Plan in order to pay for the continuation coverage.

(v) Except as provided in this paragraph the provisions of paragraph (c) apply to an election change under a benefit described under Article 4.01(b). A participant may reduce an election for a benefit described under 4.01(b) due to a change in status if and only if the employee's legal marital status changes due to death, divorce, annulment, or legal separation, or there is a reduction in the number of dependents of the employee (as defined in section 152 of the Internal Revenue Code) due to death.

(d) *Judgment, decree, or order.* This paragraph (d) applies to a judgment, decree, or order ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in section 609 of the Employee Retirement Income Security Act of 1974) that requires accident or health coverage for an employee's child. Notwithstanding the provisions of paragraph (c) of this section, an employee may—

1. Make an election change to a plan described under sections 4.01(a), 4.01(b), 4.01(d), 4.01(e), or 4.01(g) to provide coverage for the child if the order requires coverage under the employee's plan; or

2. Make an election change to a plan described under sections 4.01(a), 4.01(b), 4.01(d), 4.01(e), or 4.01(g) to cancel coverage for the child if the order requires the former spouse to provide coverage.

(e) *Entitlement to Medicare or Medicaid.* If an employee, spouse, or dependent becomes entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), an employee may make an election change to a plan described under sections 4.01(a), 4.01(d), 4.01(e), or 4.01(g) to cancel coverage of that employee, spouse, or dependent under the accident or health plan. In addition, if an employee, spouse, or dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, an employee may make an election change to commence or increase coverage under a plan described under sections 4.01(a), 4.01(d), 4.01(e), or 4.01(g).

(f) *Coverage or cost changes.* Changes allowed under this section are not applicable to Flexible Medical Benefits as described in section 4.01(b). Therefore, no changes to an election for Flexible Medical Benefits is allowed due to events described in this section (f).

1. *Cost changes.* A participant's plan described under Article 4.01(a), 4.01(d), 4.01(e), or 4.01(g) will automatically be changed to reflect a change in the cost of coverage. Alternatively, if the premium amount significantly increases a participant

may revoke an election and, in lieu thereof, to receive on a prospective basis, coverage under another health plan with similar coverage.

2. *Coverage changes.* If the coverage under a plan is significantly curtailed or ceases during a period of coverage, affected employees may revoke his/her election under the plan and may make a new election on a prospective basis for coverage under another plan option providing similar coverage. Coverage under an accident or health plan is significantly curtailed only if there is an overall reduction in coverage provided to participants under the plan so as to constitute reduced coverage to participants generally. For example, the loss of a participant's primary care physician would not be a significant curtailment because it does not affect participants in general.

Addition (or elimination) of a plan option providing similar coverage. If during a period of coverage the plan adds a new plan option or other coverage option (or eliminates an existing plan option or other coverage option) affected employees may elect the newly-added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other plan options providing similar coverage.

3. *Change in coverage of spouse or dependent under other employer's plan.* An employee may make a prospective election change to a plan described under sections 4.01(a), 4.01(d), 4.01(e), or 4.01(g) that is on account of and corresponds with an election made under the plan of the spouse's, former spouse's or dependent's employer if the period of coverage under the cafeteria plan or qualified plan of the spouse's, former spouse's, or dependent's employer only allows elections for periods of coverage different than the Plan Year for the MSECP.

(g) *Special requirements concerning the Family and Medical Leave Act.*

An employee taking FMLA leave may revoke an existing election for the remaining portion of the coverage period. Upon returning from FMLA leave, an employee may choose to be reinstated in any benefit described under this plan if such coverage was terminated during the FMLA leave (either by revocation or nonpayment of premiums). Such reinstatement will be on the same terms as prior to taking FMLA leave. However, the employee has no greater right to benefits for the remainder of the Plan Year than an employee who has been continuously working during the Plan Year. In addition to the rights granted under FMLA, such an employee has the right to revoke or change elections under the same terms and conditions as are available to employees participating in the Cafeteria Plan who are not on FMLA leave.

If an employee's coverage under a benefit described in section 4.01(b) or 4.01(c) terminates while the employee is on FMLA leave, the employee is not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. If that employee subsequently elects to be reinstated in a benefit previously terminated upon return from FMLA leave for the remainder of the Plan Year, the employee may not retroactively elect coverage for claims incurred during the period when the coverage was terminated. Further, the employee is not entitled to greater benefits relative to premiums paid than an employee who has been continuously working during the Plan Year. Therefore, if an employee elects to be reinstated in a benefit described above upon return from FMLA leave, the employee's coverage for the remainder of the Plan Year is equal to the employee's election for the 12-month period of coverage (or such shorter period as provided under section 3.03 or this section 3.09), prorated for the period during the FMLA leave for which no premiums were paid, and reduced by prior reimbursements.

(h) *Effective date of election changes.*

Any increase in the election amount designated by a participant made due to a change in status may include only those expenses which the participant expects to incur at a time during the period of coverage subsequent to the effective date of the increase. Any increase or decrease to an election amount for a program described in the Plan document under Article Four, section 4.01(b) or 4.01(c) shall be effective with the first day of the month coincident with or next following the Plan Administrator's receipt and approval of written notification of the new election. Any increase or decrease to an election amount for a program described in the Plan document under Article Four, section 4.01(a), 4.01(d), 4.01(e), or 4.01(g) shall be effective with the first required premium payment after the event.

3.10 If participation terminates due to a separation of service and the individual returns to eligible employment within thirty (30) days in the same Plan Year, then the participant's election will be reinstated as it was immediately prior to the separation of service. If participation terminates due to a separation of service and the individual returns to eligible employment after thirty (30) days in the same Plan Year, then the participant may make a new election for the remainder of the Plan Year. If salary reduction contributions were not made during the separation of service, the participant will not be able to be reimbursed for expenses incurred under benefits described under sections 4.01(b) and 4.01(c) during the separation.

3.11 A claim that is determined to be fraudulent by the plan administrator shall be denied. The administrator shall refer any fraud to the Office of Administration which will forward the matter to the employee's department and appropriate law enforcement for further action. The employee making a fraudulent claim shall be barred from future participation in the plan.

#### ARTICLE FOUR AVAILABLE SELECTION OF PLAN CATEGORIES

4.01 In general, employees are automatically enrolled into 4.01(a), 4.01(d), 4.01(e), and 4.01(g) unless waiving coverage in writing and may choose to participate in 4.01(b) and 4.01(c) offered under the MSECP:

(a) *State-Sponsored Medical Insurance*— This category provides for the direct payment to the insurance provider of the participant's share of the cost or premium for coverage under any plan or program which provides medical benefits or health insurance to or on behalf of any employee or spouse or dependent in the event of illness or personal injury to the employee or spouse or dependent, which plan or program is available to the employee by reason of status as an employee. The term plan or program, for purposes of this article, shall include any group insurance or other plan which is either provided by the Missouri Consolidated Health Care Plan (MCHCP), Missouri Department of Transportation and Missouri State Highway Patrol Medical & Life Insurance Plan, or Conservation Employees Benefits Plan Trust Fund, or is obtained by competitive bid and is not duplicative of any other plan provided by the State of Missouri. This article shall expressly include any Health Maintenance

Organization (HMO) to which the employer makes a contribution on behalf of a participant;

(b) *Flexible Medical Benefits*—This category provides for payment to the participant of the cost of medical care for the participant or spouse or dependents of the participant. Such expenses must be incurred pursuant to the terms of the separate but related MSEFMBP (Appendix C), established in conjunction with the MSECPC;

(c) *Dependent Care Assistance*—This category provides for payment to the participant of employment-related expenses for the care of the spouse or dependents of the participant. Such expenses must be incurred pursuant to the terms of the separate but related MSEDCA (Appendix B) established concurrently with the MSECPC;

(d) *State-Sponsored Dental Insurance*—This category provides for the direct payment to the insurance provider of the participant's share of the cost or premium for coverage under any plan or program which provides dental benefits or dental insurance to or on behalf of any employee or spouse or dependent, which plan or program is available to the employee by reason of status as an employee. The term plan or program, for purposes of this article, shall include any group insurance or other plan which is either provided by the Missouri Consolidated Health Care Plan (MCHCP), or is obtained by competitive bid;

(e) *State-Sponsored Vision Care Insurance*—This category provides for the direct payment to the insurance provider of the participant's share of the cost or premium for coverage under any plan or program which provides vision care benefits or vision care insurance to or on behalf of any employee or spouse or dependent, which plan or program is available to the employee by reason of status as an employee. The term plan or program, for purposes of this article, shall include any group insurance or other plan which is either provided by the Missouri Consolidated Health Care Plan (MCHCP), or is obtained by competitive bid;

(f) *Cash*; and

(g) *Other Products*—This category provides for the direct payment to the insurance provider of the participant's share of the cost or premium for coverage under any qualified plan or program which provides any other qualified product eligible under Section 125 of the United States Code, to or on behalf of any employee or spouse or dependent, which plan or program is available to the employee through a payroll deduction agreement with the vendor.

#### ARTICLE FIVE

##### GENERAL PROVISIONS REGARDING PLANS

5.01 No expenditure of any nature shall qualify for payment or reimbursement under the MSECPC unless the expense is for the participant, the participant's spouse, or the participant's dependent. Such expenses must be incurred during the participant's period of coverage and must be related to the particular plan selection made by the participant at the time of enrollment for the period of coverage. For purposes of the MSECPC, a period of coverage is any Plan Year (including an initial short Plan Year) or, in the case of participants subject to the MSECPC, section 3.03, a period of coverage extends from the first day of the month coincident with or next following the hire date through the end of the Plan Year unless waiving coverage of the plan. In the case of medical expenses, an expense will be considered as having been incurred at the time the medical care related to the expense is provided and not at the time the expense is charged, billed or paid. Similarly, in the case of dependent care expenses, an expense will be considered as having been incurred at the time the dependent care related to the expense is provided.

5.02 Within forty-five (45) days following the end of each Plan Year, the Plan Administrator shall provide to each person who was a participant in the MSEFMBP or the MSEDCA at any time during the Plan Year an accounting statement reflecting contributions to and distributions from each account established for the participant during the Plan Year, including such other information as may be required by regulations promulgated by the Secretary of the Treasury or his/her delegate.

#### ARTICLE SIX

##### CONTRIBUTIONS TO PARTICIPANT ACCOUNTS

6.01 Except as provided in the MSEFMBP, section 6.03 or Article VII, contributions to the account of each participant shall be made only by the employer and shall be made as follows: On the participant's regular pay date during each Plan Year, the employer shall cause to be contributed for credit to the account of said participant an amount equal to the sum of the permissible amounts elected by the participant for all plans selected for the Plan Year divided by the number of the participant's regular pay dates in the Plan Year subsequent to the participant's effective date of participation.

6.02 Any funds remaining to the credit of a participant's account as of the close of business on December 31 of a Plan Year shall be forfeited and revert to the employer; provided, however, that all such funds shall be held for a period of not less than ninety (90) days following the end of the Plan Year and be applied to the payment or reimbursement of covered expenses that the participant incurred during the Plan Year that the funds were credited and to the extent that claims for payment or reimbursement, accompanied by appropriate evidence of the related expenditures or obligations, are submitted to the Plan Administrator within the required period following the end of the Plan Year.

#### ARTICLE SEVEN

##### ADMINISTRATION

7.01 Neither the employer nor the Plan Administrator makes any assurance to any participant that participation in the MSECPC (or the related MSEDCA or MSEFMBP) is appropriate for any participant nor guarantees any loss which may result because of any participant's participation in the MSECPC.

*7.02 The Plan Administrator shall make all determinations required respecting administration of the MSECP, including determinations as to the right of any person to a plan under the MSECP. Such determinations are final as approved by the Plan Administrator.*

*7.03 Any decision by the Plan Administrator regarding a denial of a claim for benefits or a change of election by a participant shall be stated in writing by the Plan Administrator and be delivered to the participant within thirty (30) days of the receipt by the Plan Administrator of the claim or change request; such notice shall set forth the specific reason for any denial. Any participant may file a written request with the Plan Administrator for a review of the denied claim for benefits or change of election within sixty (60) days of the notice of the denial. The Plan Administrator will notify the participant of its decision in writing within sixty (60) days of the request for review.*

*7.04 The Plan Administrator shall exercise a reasonable level of authority and responsibility in order to comply with the terms of the MSECP relating to the records of participants and amounts payable under the MSECP.*

*7.05 The Plan Administrator shall construe and interpret the MSECP, decide all questions of eligibility and determine the amount, manner and time of payment of any benefits hereunder.*

*7.06 Premium amounts returned by a medical or insurance provider or any benefit amount erroneously withheld and returned to the State by the Plan Administrator shall be deposited into the MSECP account. Allowable refunds, less required federal, state and Social Security tax withholdings, shall be issued by check payable to the participant from the MSECP account and wage reporting for tax purposes will be corrected.*

*7.07 Vendors of products included in 4.01(g) must comply with 1 CSR 10-4.010 and 1 CSR 10-15.010, and also agree to fees for the cost of administration, set by the Commissioner of Administration.*

#### **ARTICLE EIGHT MISCELLANEOUS**

*8.01 No participant shall have any right to or interest in any assets of the MSECP upon termination or otherwise except as provided under the MSECP, and then only to the extent of the benefits payable under the MSECP to such participant. All payments of benefits provided under the MSECP shall be made solely out of the assets of the employer.*

*8.02 Benefits payable under the MSECP shall not be subject to, in any manner, voluntary anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind.*

*8.03 Products included under 4.01(g) are not endorsed or provided by the State of Missouri. Solicitation by a vendor of signed employee applications or memberships may not be performed in State facilities at any time with the exception of qualified vendor products for the cafeteria plan and regulations under 1 CSR 10-15.010(3).*

#### **ARTICLE NINE AMENDMENTS AND TERMINATION**

*9.01 The employer reserves the right to make amendments to the MSECP at any time. Any amendment to the MSECP may be made with retroactive effect if determined to be necessary or desirable to comply with any applicable law or applicable regulation.*

*9.02 The employer may terminate the MSECP at any time.*

*9.03 Upon the expiration or termination of a Plan Year, the accounts of all participants affected thereby shall continue to be held by the Plan Administrator for distribution in accordance with the purposes and relevant provisions of the MSECP. If not so distributed within one hundred twenty (120) days following the last day of the expired or terminated Plan Year, balances shall thereupon be forfeited and revert to the employer.*

#### **APPENDIX B MISSOURI STATE EMPLOYEES' DEPENDENT CARE ASSISTANCE PLAN**

*The State of Missouri hereby establishes for the benefit of its employees a Dependent Care Assistance Plan (hereinafter called the MSEDCA) intended to conform to the requirements of paragraphs (2) through (8) of subsection (d) of Section 129 of the Internal Revenue Code, and in association with the Missouri State Employees' Cafeteria Plan, (Appendix A; hereinafter called the MSECP), established concurrently herewith.*

#### **ARTICLE ONE DEFINITIONS**

*1.01 "Dependent Care Assistance" means the direct payment to the participant or reimbursement to the participant for the payment of those services which are considered employment related expenses under Section 21(b)(2) of the Internal Revenue Code (relating to expenses for household and dependent care services necessary for gainful employment).*

1.02 "Incurred" means when the participant is provided with the dependent care service that gives rise to the expense, and not when the participant is formally billed, charged for, or pays for the dependent care.

1.03 All terms defined in the related MSECP document, wherever used in this MSED CAP document, shall have the same meaning as required by the definition set forth in said MSECP document.

## ARTICLE TWO STATEMENT OF PURPOSE

2.01 The purpose of this MSED CAP is to make possible the inclusion of Dependent Care Assistance in the group of benefits which may be selected by participants of the related MSECP and to satisfy the requirement of a separate written plan for a dependent care assistance program as set forth in Section 129(d)(1) of the Internal Revenue Code.

## ARTICLE THREE ELIGIBILITY

3.01 Any person who is eligible to participate in the related MSECP is eligible to select Dependent Care Assistance as an optional benefit under the MSECP subject, however, to all terms, provisions and conditions set forth herein. The establishment of this MSED CAP in the form of a separate document is not intended, nor shall it be so interpreted or construed, as expanding or enlarging the rights or privileges of any participant for payment or reimbursement above the amount set forth in the related MSECP.

## ARTICLE FOUR LIMITATIONS AND RESTRICTIONS ON PAYMENTS FROM THE PLAN

4.01 No direct payment to a participant or reimbursement to a participant for Dependent Care Assistance may be made from the MSED CAP unless the total assistance amount, including all other amounts paid to the participant for Dependent Care Assistance during the same Plan Year, does not exceed the lesser of: (a) five thousand dollars (\$5,000) (twenty-five hundred dollars (\$2,500) in the case of a married individual filing a separate return), or (b) the wages, salaries and other employee compensation of the participant if unmarried or if the participant is married does not exceed the lesser of such employee compensation of the participant or that of the participant's spouse. For purposes of this paragraph, employee compensation shall not include the total of the permissible amounts selected under the related MSECP. For each month during which a spouse is a full-time student or incapable of independent self-care, said spouse shall be deemed to be gainfully employed and to have employee compensation of two hundred fifty dollars (\$250) if there is only one (1) child or dependent and five hundred dollars (\$500) if there are two (2) or more children or dependents. A spouse is a student only if during each of five (5) calendar months during the Plan year said spouse is a full-time student at an education organization described in Internal Revenue Code Section 170(b)(1)(A)(iii).

4.02 No payment shall be made from the MSED CAP, directly or indirectly, for an obligation incurred by a participant during a Plan Year for services provided to the participant by a person who, under Internal Revenue Code Section 151(c), is allowable to the participant or the participant's spouse as a deduction for a personal exemption for the Plan Year, or who is a son, stepson, daughter or stepdaughter of the participant and is under age nineteen (19) at the close of the relevant Plan Year.

4.03 No direct payment to a participant or reimbursement to a participant for Dependent Care Assistance may be made from the MSED CAP in excess of the available funds in the individual participant's account. No reimbursements for any Plan Year will be made prior to February 1 of that Plan Year.

4.04 Claims for payment or reimbursement must be accompanied by invoices or such other reasonable evidence of expenditure as may be satisfactory to the Plan Administrator. Such evidence must include a written statement from an independent third party stating the date that the expense was incurred and the amount of such expense along with a signed statement from the participant that the expense has not been reimbursed and will not be reimbursed from any other source.

## ARTICLE FIVE MISCELLANEOUS

5.01 Reasonable notification of the availability and terms of the MSED CAP and the related MSECP shall be provided by the employer to all employees.

5.02 On or before each January 31, the employer shall furnish to each participant under the MSED CAP a statement (form W-2) showing the total amount redirected under the Plan for payment of dependent care expenses incurred by the participant during the previous calendar year.

## ARTICLE SIX AMENDMENT AND TERMINATION

6.01 The employer reserves to itself the right to amend this MSED CAP in any manner which it deems to be necessary or



*desirable and shall amend the MSED CAP in any respect necessary to conform the same to the provisions of the Internal Revenue Code or relevant regulations promulgated thereunder, and further reserves the right to terminate the MSED CAP by appropriate action.*

APPENDIX C  
MISSOURI STATE EMPLOYEES' FLEXIBLE MEDICAL BENEFITS PLAN

*The State of Missouri hereby establishes for the benefit of its employees a Flexible Medical Benefits Plan (hereinafter called the MSEFMBP) intended to conform to the requirements of Section 105(b) of the Internal Revenue Code and in association with the Missouri State Employees' Cafeteria Plan (Appendix A, hereinafter called the MSEC P), established concurrently herewith.*

ARTICLE ONE  
DEFINITIONS

*1.01 "Medical care expense" means expenses incurred by a participant, spouse or dependent for medical care to the extent that the participant or other person incurring the expense is not reimbursed for the expense through any other accident or health plan, as defined in United States Code Section 213(d). Expenses for premiums or contributions made to any other health or accident plan (whether or not maintained by the employer) and long-term care expenses are not considered Medical Care Expenses for the purposes of this Plan.*

*1.02 "Incurred" means when the participant is provided with the medical care that gives rise to the expense, and not when the participant is formally billed, charged for, or pays for the medical care.*

*1.03 All terms defined in the related MSEC P document, whenever used in this MSEFMBP document, shall have the same meaning as required by the definition set forth in said MSEC P document.*

*1.04 "Covered individual" means the participant, the participant's spouse or a dependent of the participant as defined in the MSEC P.*

*1.05 "Employer" means the State of Missouri including any agency, or department of the State of Missouri other than the University of Missouri and Southeast Missouri State University.*

*1.06 "PHI" means protected health information.*

*1.07 "Protected health information" means information that is created or received by MSEFMBP and relates to the past, present, or future physical or mental health or condition of a covered individual; the provision of health care to a covered individual; or the past, present, or future payment for the provision of health care to a covered individual; and that identifies the covered individual or for which there is a reasonable basis to believe the information can be used to identify the covered individual. Protected health information includes information of persons living or deceased.*

ARTICLE TWO  
STATEMENT OF PURPOSE

*2.01 The purpose of this MSEFMBP is to make possible the inclusion of medical expenses in the group of benefits which may be selected by participants of the related MSEC P and to satisfy the requirement of a written plan with respect to a medical expenses plan as set forth in the Internal Revenue Code.*

ARTICLE THREE  
ELIGIBILITY

*3.01 Any person who is eligible to participate in the related MSEC P is eligible to select Flexible Medical Benefits as an optional benefit under the MSEC P subject, however, to all terms, provisions and conditions set forth herein. The establishment of this MSEFMBP in the form of a separate document is not intended, nor shall it be so interpreted or construed, as expanding or enlarging the rights or privileges of any participant for payment or reimbursement above the amount set forth in the related MSEC P.*

*3.02 Participants who elect to participate in this MSEFMBP shall elect to participate for the full Plan Year. Participants may arrange to have contributions made to the Plan as specified in the MSEC P, section 6.01, so long as the participant remains an employee of the employer. Participation and coverage shall cease upon separation of service as of the last day of the month in which the last contribution was received.*

*3.03 No participant in this MSEFMBP may modify or revoke an election with respect to the Plan Year, except under the conditions specified in MSEC P, section 3.09. In no case may a decrease in the amount of election result in a return of contributions to the participant.*

ARTICLE FOUR  
LIMITATIONS AND RESTRICTIONS ON PAYMENTS FROM THE PLAN

4.01 Medical care expenses as defined herein will be eligible for payment from the MSEFMBP to the extent of the permissible amount selected by the participant pursuant to the MSECP, sections 3.04 and 4.01(b). Claims paid by any other accident or health plan, whether or not maintained by the employer, are not reimbursable under this MSEFMBP.

4.02 Claims for reimbursement of medical care expenses must be submitted to the Plan Administrator and must be accompanied by invoices or such other reasonable evidence of the expenditure as may be satisfactory to the Plan Administrator. Such evidence must include a written statement from an independent third party stating the date the medical expense was incurred and the amount of such expense along with a signed statement from the participant that the expense has not been reimbursed and will not be reimbursed from any other source. In no event shall it be the responsibility of the Plan Administrator or the Office of Administration to make inquiry concerning the accuracy of any such statement or certification. No reimbursements for any Plan Year will be made prior to February 1 of that Plan Year.

4.03 No payment of medical care expenses shall be made from the MSEFMBP to any participant which is in excess of the amount designated by the participant as the permissible amount defined in the MSECP, section 3.04.

4.04 No payment shall be made for any medical care expense incurred after a participant has ceased being a participant in this MSEFMBP.

4.05 Payments to participants shall be suspended whenever the designated contribution amount is not received by the time the next required payment is due. Payments will resume when the required contribution amounts are paid in full.

ARTICLE FIVE  
MISCELLANEOUS

5.01 Reasonable notification of the availability and terms of this MSEFMBP and the related MSECP shall be provided by the employer to all employees.

5.02 Within forty-five (45) days following the end of each Plan Year, the Plan Administrator shall furnish to each participant under this MSEFMBP a written statement showing the amounts paid for medical expenses claimed by the participant relating to the previous calendar year.

ARTICLE SIX  
CONTINUATION COVERAGE

6.01 In accordance with Section 42 United States Code 300bb, and notwithstanding any other provision in the MSEFMBP, a participant or his/her spouse or dependent may be eligible to elect to continue the coverage under the MSEFMBP though the participant's election to receive benefits expired or was terminated, under the following circumstances:

- (a) Death of the participant;
- (b) Termination (other than for gross misconduct) or reduction of hours of the participant;
- (c) Divorce or legal separation of the participant; and
- (d) A dependent child ceasing to be a dependent child under the terms of this plan.

The right to continuation coverage shall only be available if on the date of the qualifying event the participant's remaining benefits for the current plan year are greater than the participant's remaining premium payments.

6.02 When the MSEFMBP is notified that one of the events described in section 6.01 has happened, it will in turn notify the eligible person(s) of the right to choose continuation coverage. The election period for continuation coverage begins when coverage would otherwise terminate under the MSEFMBP and ends sixty (60) days after the latter of the date when coverage would otherwise terminate, or the date notice of the right to continue coverage is provided by the Plan Administrator. It is the responsibility of the employee-participant or a responsible family member to inform the Plan Administrator of the occurrence of the event according continuation coverage and the election to apply for continuation coverage based upon the events described in section 6.01(c) and 6.01(d) above. It is the responsibility of the employer to inform the Plan Administrator of the occurrence of the event according continuation coverage and the election to apply for continuation coverage based upon the events described in section 6.01(a) and 6.01(b) above.

6.03 A premium may be charged to the participant, spouse or dependent, as the case may be, for any period of continuation coverage equal to not more than one hundred two percent (102%) of the cost of providing coverage for the period to similarly situated participants, spouses or dependents. Any additional premium amount in excess of one hundred percent (100%) of the cost of providing coverage for the period to similarly situated participants, spouses or dependents, shall not be credited to the participant's account and shall be treated as an additional administrative charge. Continuation coverage will not extend beyond the end of the current plan year. However, coverage may terminate earlier if:

- (a) The employer ceases to provide any medical reimbursement plans to any employee;
- (b) The premiums described above are not paid within thirty (30) days of their due date; or
- (c) A party electing continuation coverage becomes covered under another group health plan or entitled to Medicare benefits.

6.04 Payments for expenses incurred during any period of continuation shall not be made until the contributions for that period are received by the MSECP.

6.05 Continuation coverage shall be provided in accordance with the requirements of Section 42 U.S.C. 300bb, all of which requirements are incorporated herein by reference.

ARTICLE SEVEN  
FAMILY AND MEDICAL LEAVE

7.01 An employee is entitled to continue coverage under the MSEFMBP during FMLA leave or during a period of duty in the Uniformed Services lasting more than thirty-one (31) days. An employee making premium payments who chooses to continue coverage while on FMLA leave is responsible for the share of premiums that the employee was paying while working.

7.02 An employee who continues coverage while on paid or unpaid FMLA leave may choose from one or both of the following payment options. These options are referred to in this section as pre-pay and pay-as-you-go.

(a) Pre-pay.

(1) Under the pre-pay option, an employee may pay, prior to commencement of the FMLA leave period, the amounts due for the FMLA leave period.

(2) Contributions under the pre-pay option may be made on a pre-tax salary reduction basis from any taxable compensation.

(3) Contributions under the pre-pay option may also be made on an after-tax basis.

(b) Pay-as-you-go.

(1) Under the pay-as-you-go option, employees may pay their premium payments on the same schedule as payments would be made if the employee were not on leave or under any other payment schedule permitted by the Labor Regulations at 29 CFR 825.210(c) (i.e., on the same schedule as payments are made under the Consolidated Omnibus Reconciliation Act of 1985, Public Law 99-272; under the employer's existing rules for payment by employees on leave without pay; or under any other system voluntarily agreed to between the employer and the employee that is not inconsistent with this section or with 29 CFR 825.210(c)).

(2) Contributions under the pay-as-you-go option may be made on a pre-tax basis to the extent that the contributions are made from taxable compensation that is due the employee during the leave period, and provided that all cafeteria plan requirements are satisfied.

(3) Coverage under the MSEFMBP will be terminated for any employee who fails to make required premium payments while on FMLA leave.

ARTICLE EIGHT  
AMENDMENT AND TERMINATION

8.01 The employer reserves to itself the right to amend this MSEFMBP in any manner which it deems to be necessary or desirable and shall amend the MSEFMBP in any respect necessary to conform to the provisions of the Internal Revenue Code, or relevant regulations promulgated thereunder, and further reserves the right to terminate the MSEFMBP by appropriate action.

ARTICLE NINE  
PRIVACY POLICY

9.01 The MSEFMBP will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

9.02 Meaning of Payment.

Payment has the meaning specified in the Code of Federal Regulations §164.501, specifically:

(1) The activities undertaken by:

i. A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or

ii. A health care provider or health plan to obtain or provide reimbursement for the provision of health care; and

(2) The activities in paragraph (1) of this definition relate to the individual to whom health care is provided and include, but are not limited to:

i. Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

ii. Risk adjusting amounts due based on enrollee health status and demographic characteristics;

iii. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;

iv. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

v. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and

*vi. Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement:*

- A. Name and address;*
- B. Date of birth;*
- C. Social security number;*
- D. Payment history;*
- E. Account number; and*
- F. Name and address of the health care provider and/or health plan.*

#### **9.03 Meaning of Health Care Operations.**

*Health care operations has the meaning as specified in the Code of Federal Regulations §164.501, specifically, health care operations means any of the following activities of the covered entity to the extent that the activities are related to covered functions:*

*(1) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;*

*(2) Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;*

*(3) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of §164.514(g) are met, if applicable;*

*(4) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;*

*(5) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and*

*(6) Business management and general administrative activities of the entity, including, but not limited to:*

- i. Management activities relating to implementation of and compliance with the requirements of this subchapter;*
- ii. Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer;*
- iii. Resolution of internal grievances;*
- iv. The sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and*
- v. Consistent with the applicable requirements of §164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.*

#### **9.04 As required by law and authorization.**

*The MSEFMBP will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary. With an authorization, the MSEFMBP will disclose PHI to the Employer's other medical, disability and workers' compensation plans for purposes related to administration of those plans.*

#### **9.05 Disclosures to the Employer.**

*The MSEFMBP will disclose PHI to the Employer as sponsor of the MSEFMBP provided that the Employer agrees to:*

- (1) Not use or further disclose PHI other than as permitted or required by this MSEFMBP document or as required by law;*
- (2) Ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the MSEFMBP agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;*
- (3) Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual;*
- (4) Not use or disclose PHI in conjunction with any other benefit or employee benefit plan of the Employer unless authorized by the individual;*
- (5) Report to the MSEFMBP any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;*
- (6) Make PHI available to an individual in accordance with HIPAA's access requirements;*
- (7) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;*
- (8) Make available the information required to provide an accounting of disclosures;*
- (9) Make internal practices, books and records relating to the use and disclosure of PHI received from the MSEFMBP available to the Secretary of Health and Human Services for the purposes of determining the MSEFMBP's compliance with HIPAA; and*
- (10) If feasible, return or destroy all PHI received from the MSEFMBP that the Employer still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).*

#### **9.06 Employees with access to PHI.**

*In accordance with HIPAA, only the following employees of the Employer will be given access to PHI solely for the purpose*

*of performing Employer Plan administrations functions:*

*(1) Any employee responsible for establishing and maintaining employee deduction and reduction records for the Employer;*

*(2) Any employee with oversight responsibility for management of the MSEFMBP or any component of the MSEFMBP.*

*If the above employees do not comply with this MSEFMBP document, the Employer shall provide a mechanism for resolving issues of noncompliance including disciplinary sanctions.*

**9.07 HIPAA Compliance.**

*It is intended that this MSEFMBP meet all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA) and of all regulations issued thereunder. This MSEFMBP shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this MSEFMBP and HIPAA, the provisions of HIPAA shall be deemed controlling, and any conflicting part, clause or provision of this MSEFMBP shall be deemed superseded to the extent of the conflict.]*

**APPENDIX A**  
**MISSOURI STATE EMPLOYEES' CAFETERIA PLAN DOCUMENT**

**Cafeteria Plan  
for the Employees of  
the State of Missouri**

**Plan Document**

**Effective January 1, 2011  
(with an original effective date of January 1, 1992)**

<b>Cafeteria Plan for the Employees of the State of Missouri</b>		
<b>Plan Document</b>		
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**Section 1  
Introduction****1.1 Establishment of the Plan**

The State of Missouri (the "Employer") hereby amends the State of Missouri Cafeteria Plan (the "Plan") effective January 1, 2011 (the "Effective Date"). The original Plan was effective January 1, 1992.

**1.2 Purpose of the Plan**

This Plan allows an Employee to participate in the following Benefit Options:

- **Premium Payment Plan (PPP)** to make pre-tax Salary Reduction Contributions to pay the Employee's share of the premium or contribution for the Health Plan.
- **Health Flexible Spending Account (Health FSA)** to make pre-tax Salary Reduction Contributions to an account for reimbursement of certain Health Care Expenses.
- **Dependent Care Assistance Program (DCAP)** to make pre-tax Salary Reduction Contributions to an account for reimbursement of certain Dependent Care Expenses.
- **Health Savings Account Contribution Benefit (HSA Contribution Benefit)** to make pre-tax Salary Reduction Contributions to a Health Savings Account.

**1.3 Legal Status**

This Plan is intended to qualify as a "cafeteria plan" under the Code §125, and regulations issued thereunder and shall be interpreted to accomplish that objective.

The Health FSA is intended to qualify as a self-insured health reimbursement plan under Code §105, and the Health Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees' gross income under Code §105(b).

The DCAP is intended to qualify as a dependent care assistance program under Code §129, and the Dependent Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees' gross income under Code §129(a).

The HSA Contribution Benefit is intended to meet all requirements of §223 of the Code.

Although reprinted within this document, the Health FSA, the DCAP and the HSA Contribution Benefit are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §§105 and 129. The Health FSA is also a separate plan for purposes of applicable provisions of COBRA and HIPAA.

**1.4 Capitalized Terms**

Many of the terms used in this document begin with a capital letter. These terms have special meaning under the Plan and are defined in the Glossary at the end of this document or in other



**relevant Sections. When reading the provisions of the Plan, please refer to the Glossary at the end of this document. Becoming familiar with the terms defined there will provide a better understanding of the procedures and Benefits described.**

<p style="text-align: center;">Section 2 General Information</p>
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<b>Name of the Cafeteria Plan</b>	<b>State of Missouri Cafeteria Plan</b>
<b>Name of Employer</b>	<b>State of Missouri</b>
<b>Address of Plan</b>	<b>Office of Administration, P.O. Box 809, Jefferson City, MO 65102-0809</b>
<b>Plan Administrator</b>	<b>State of Missouri/Office of Administration</b>
<b>Plan Sponsor and its IRS</b>	<b>State of Missouri/Office of Administration</b>
<b>Employer Identification Number</b>	<b>44-6000987</b>
<b>Named Fiduciary &amp; Agent for Service of Legal Process</b>	<b>State of Missouri</b>
<b>Type of Administration</b>	<b>The Plan is administered by the Plan Administrator with Benefits provided in accordance with the provisions of the State of Missouri Cafeteria Plan. It is not financed by an insurance company and Benefits are not guaranteed by a contract of insurance. State of Missouri may hire a third party to perform some of its administrative duties such as claim payments and enrollment.</b>
<b>Plan Number</b>	<b>501</b>
<b>Benefit Option Year</b>	<b>The twelve-month period ending December 31.</b>
<b>Plan Effective Date</b>	<b>January 1, 2011, with an original effective date of January 1, 1992</b>
<b>Claims Administrator</b>	<b>Application Software, Inc., dba ASI, dba ASIFlex</b>
<b>Plan Renewal Date</b>	<b>January 1</b>
<b>Internal Revenue Code and Other Federal Compliance</b>	<b>It is intended that this Plan meet all applicable requirements of the Internal Revenue Code of 1986 (the "Code") and other federal regulations. In the event of any conflict between this Plan and the Code or other federal regulations, the provisions of the Code and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.</b>
<b>Discretionary Authority</b>	<b>The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine the appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained.</b>

In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all Plan documents, and make all interpretive and factual determinations as to whether any individual is entitled to receive any Benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation shall be subject to review only if it is arbitrary, capricious, or otherwise an abuse of discretion.

Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any Benefits or making any claim for Benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes in its sole discretion and further constitutes agreement to the limited standard and scope of review described by this section -- Section 2.

**Section 3**  
**Benefit Options and Method of Funding****3.1 Benefits Offered**

Each Employee may elect to participate in one or more of the following Benefits:

- **Premium Payment Plan (PPP)** as described in Schedule A.
- **Health Flexible Spending Account (Health FSA)** as described in Schedule B.
- **Health Savings Account Contribution Benefit (HSA Contribution Benefit)** as described in Schedule C.
- **Dependent Care Assistance Program (DCAP)** as described in Schedule D.

Benefits under the Plan shall not be provided in the form of deferred Compensation.

**3.2 Employer and Participant Contributions**

- **Employer Contributions.** The Employer may, but is not required to, contribute to any of the Benefit Options. There are no Employer Contributions for the PPP under this Plan; however, if the Participant elects the PPP as described in Schedule A, the Employer may contribute toward the Health Plan as provided in the respective plan or policy of the Employer.
- **Participant Contributions.** The Employer shall withhold from a Participant's Compensation by Salary Reduction on a pre-tax basis, or with after-tax deductions, an amount equal to the Contributions required for the Benefits elected by the Participant under the Salary Reduction Agreement. The maximum amount of Salary Reductions shall not exceed the aggregate cost of the Benefits elected.

**3.3 Computing Salary Reduction Contributions**

- **Salary Reductions per Pay Period.** The Participant's Salary Reduction is an amount equal to:
  - The annual election for such Benefits payable on a semi-monthly or monthly basis in the Period of Coverage;
  - An amount otherwise agreed upon between the Employer and the Participant; or
  - An amount deemed appropriate by the Plan Administrator. (Example: in the event of a shortage of reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate.)
- **Salary Reductions Following a Change of Elections.** If the Participant changes his or her election under the PPP, Health FSA, or DCAP, as permitted under the Plan, the Salary Reductions will be, for the Benefits affected, calculated as follows:
  - An amount equal to:

- The new annual amount elected pursuant to the Method of Timing and Elections section below;
- Less the aggregate Contributions, if any, for the period prior to such election change;
- Payable over the remaining term of the Period of Coverage commencing with the election change;
- An amount otherwise agreed upon between the Employer and the Participant; or
- An amount deemed appropriate by the Plan Administrator. (Example: in the event of a shortage of reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate.)
- **Salary Reductions Considered Employer Contributions for Certain Purposes.** Salary Reductions to pay for the Participant's share of the Contributions for Benefit Options elected for purposes of this Plan and the Code are considered Employer Contributions.
- **Salary Reduction Balance Upon Termination of Coverage.** If, as of the date that coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the required Contributions necessary for Benefit Options elected up to the date of termination, the Employer will either return the excess to the Participant as additional taxable wages or recoup the amount due through Salary Reduction amounts from any remaining Compensation.
- **After-Tax Contributions for PPP.** After-tax Contributions for the Health Plan will be paid outside of this Plan.

#### **3.4 Funding This Plan**

- **Benefits Paid from General Assets.** All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer nor the Plan Administrator to maintain any fund or to segregate any amount for the Participant's benefit. Neither the Participant, nor any other person, shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets, it may hire a third party administrator to perform some of its administrative duties such as claims payments and enrollment.
- **Participant Bookkeeping Account.** While all Benefits are to be paid from the general assets of the Employer, the Employer will keep a bookkeeping account in the name of each Participant. The bookkeeping account is used to track allocation and payment of Plan Benefits. The Plan Administrator will establish and maintain under each Participant's bookkeeping account a subaccount for each Benefit Option elected by each Participant.
- **Maximum Contributions.** The maximum Contributions that may be made under this Plan for the Participant are the total of the maximums that may be elected for the PPP as described in

**Schedule A, Health FSA as described in Schedule B, HSA Contribution Benefit as described in Schedule C and the DCAP as described in Schedule D.**

**Section 4**  
**Eligibility and Participation**

**4.1 Eligibility to Participate**

An individual is eligible to participate in this Plan if such individual meets the definition of Employee as set forth in the Glossary.

Eligibility requirements to participate in the individual Benefit Options may vary from the eligibility requirements to participate in this Plan.

**4.2 Required Salary Reduction Agreement**

To participate in the Health FSA or DCAP, an Employee must complete, sign and return to the Plan Administrator a Salary Reduction Agreement by the deadline designated by the Plan Administrator. If an Employee fails to return a Salary Reduction Agreement, the Employee is deemed to have elected cash and will not be allowed to change such election until the next Open Enrollment unless the Employee experiences an event permitting an election change mid-year.

The Employee may begin participation on the 1st of the month coincident with or next following the date on which the Employee has met the Plan's eligibility requirements or in accordance with the Enrollment requirements each year.

**4.3 Termination of Participation**

A Participant will terminate participation in this Plan upon the earlier of:

- The expiration of the Period of Coverage for which the Employee has elected to participate unless during the Open Enrollment Period for the next Plan Year the Employee elects to continue participating;
- The termination of this Plan; or
- The date on which the Employee ceases to be an Employee because of retirement, termination of employment, layoff, reduction in hours, or any other reason. Eligibility may continue beyond such date for purposes of COBRA coverage, where applicable as set forth in the respective Schedule attached hereto, as may be permitted by the Plan Administrator on a uniform and consistent basis, but not beyond the end of the current Plan Year.

**False or Fraudulent Claims.** The Plan Administrator has the authority to terminate participation in the Plan if it has been determined that a Participant has filed a false or fraudulent claim for Benefits. In addition, an Employee filing a false or fraudulent claim is subject to disciplinary action, up to and including termination of employment.

Termination of participation in this Plan will automatically revoke the Participant's participation in the elected Benefit Options, according to the terms thereof.

**4.4 Rehired Employees**

If a Participant terminates employment with the Employer for any reason, including, but not limited to, disability, retirement, layoff, leave of absence without pay, or voluntary resignation, and then is rehired within the same Plan Year and within 30 days or less of the date of termination of employment, the Employee will be reinstated with the same elections that the Participant had prior to termination. If the Employer rehires a former Participant within the same Plan Year but more than 30 days following termination of employment and the Participant is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire.

**4.5 Eligibility Rules Regarding the Health FSA**

An Employee enrolled in a Health Savings Account (HSA) is not eligible to enroll in the Health FSA.

**4.6 Eligibility Rules Regarding the HSA Contribution Benefit**

An Employee must be an HSA Employee to elect to participate in the HSA Contribution Benefit Plan.

Only Employees who satisfy the following conditions may be considered an HSA Employee:

- Covered under a qualifying High Deductible Health Plan (HDHP) maintained by the Employer;
- Opened an HSA with the custodian chosen by the Employer;
- Not covered under any other non-HDHP maintained by one Employer that is determined by the Employer to offer disqualifying health coverage;
- Not claimed as a tax dependent by anyone else;
- Not enrolled in Medicare coverage; and
- Eligible to participate in the Plan.

**4.7 FMLA Leaves Of Absence**

**Health Benefits.** Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under FMLA then to the extent required by FMLA, the Participant will be entitled to continue the Benefits that provide health coverage on the same terms and conditions as if the Participant were still an active Employee. For example, the Employer will continue to pay its share of the Contribution to the extent the Participant opts to continue coverage. In the event of unpaid FMLA leave, a Participant may elect to continue such Benefits.

If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contribution:

- With after-tax dollars, by sending monthly payments to the Employer's designee by the due date established by the Employer;



- With pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any; or
- By pre-paying all or a portion of the Contribution for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation.

To pre-pay the Contribution, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available. Pre-tax dollars may not be used to fund coverage during the next Plan Year.

Coverage will terminate if Contributions are not received by the due date established by the Employer. If a Participant's coverage ceases while on FMLA leave for any reason, including for non-payment of Contributions, the Participant will be entitled to re-enter upon return from such leave on the same basis as the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA.

A Participant whose coverage ceased under any of the aforementioned plans will be entitled to elect whether to be reinstated in such plans at the same coverage level as in effect before the FMLA leave with increased Contributions for the remaining Period of Coverage, or at a coverage level that is reduced pro-rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro-rata for the period of FMLA leave, the amount withheld from a Participant's Compensation on a payroll-by-payroll basis for the purpose of paying for his or her Contributions will be equal to the amount withheld prior to the period of FMLA leave.

**Non-Health Benefits.** If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as DCAP Benefits) is to be determined by the Employer's policy for providing such Benefits when the Participant is on leave not qualified as an FMLA leave of absence, as described below. If such policy permits a Participant to discontinue Contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

#### **4.8 Non-FMLA Leaves of Absence**

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax Contributions while on leave or with catch-up Contributions after the leave ends, as may be determined by the Plan Administrator.

If a Participant goes on an unpaid leave that affects eligibility, the election change rules set forth by this Plan will apply. To the extent COBRA applies, the Participant may continue coverage under COBRA.

#### **4.9 Death**

A Participant's beneficiaries or representative of the Participant's estate, may submit claims for expenses that the Participant incurred through the date of death. A Participant may designate a

specific beneficiary for this purpose. If no beneficiary is specified, the Plan Administrator or its designee may designate the Participant's Spouse, another Dependent, or representative of the estate. Claims incurred by the Participant's covered Spouse or any other of the Participant's covered Dependents prior to the end of the month in which the Participant dies may also be submitted for reimbursement.

#### **4.10 COBRA**

Under the COBRA rules, as discussed in the attached Schedules B and C, where applicable, the Participant's Spouse and Dependents may be able to continue to participate under the Health FSA through the end of the Period of Coverage in which the Participant dies. The Participant's Spouse and Dependents may be required to continue making Contributions to continue their participation.

#### **4.11 USERRA**

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under USERRA, then to the extent required by USERRA, the Employer will continue the Benefits that provide health coverage on the same terms and conditions as if the Participant were still an active Employee. In the event of unpaid USERRA leave, a Participant may elect to continue such Benefits during the leave.

If the Participant elects to continue coverage while on USERRA leave, then the Participant may pay his or her share of the Contribution with:

- After-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer; or
- Pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any, including unused sick days and vacation days.

Coverage will terminate if Contributions are not received by the due date established by the Employer. If a Participant's coverage ceases while on USERRA leave for any reason, including for non-payment of Contributions, the Participant will be entitled to re-enter such Benefit upon return from such leave on the date of such resumption of employment and will have the same opportunities to make elections under this Plan as persons returning from non-USERRA leaves. Regardless of anything to the contrary in this Plan, an Employee returning from USERRA leave has no greater right to Benefits for the remainder of the Plan Year than an Employee who has been continuously working during the Plan Year.

Section 5  
**Method of Timing and Elections**

**5.1 Initial Election**

An Employee must complete, sign and return a Salary Reduction Agreement within the election-period set forth therein to enroll in the Benefit Options, other than the PPP.

Unless otherwise specified by the Employer, an Employee who first becomes eligible to participate in the Plan mid-year will commence participation on the 1st day of the month coinciding with or after the date the Employee completes, signs and returns a Salary Reduction Agreement or completes a Salary Reduction Agreement using the electronic system produced by the Employer (if any), within the election period set forth therein.

Eligibility for Benefits shall be subject to the additional requirements, if any, specified in the applicable Benefit Option (see Glossary for definition). The provisions of this Plan are not intended to override any exclusions, eligibility requirements or waiting periods specified in the applicable Benefit Options.

**5.2 Open Enrollment**

During each Open Enrollment Period, the Plan Administrator shall make available a Salary Reduction Agreement to each Employee who is eligible to participate in the Plan. The Salary Reduction shall enable the Employee to elect to participate in the Benefit Options for the next Plan Year, and to authorize the necessary Salary Reductions to pay for the Benefits elected. The Employee must complete sign and return the Salary Reduction Agreement or complete an election using the electronic system provided by the Employer, if any, to the Plan Administrator on or before the last day of the Open Enrollment Period. There is an exception of automatic elections in the PPP.

If an Employee makes an election to participate during an Open Enrollment Period, then the Employee will become a Participant on the first day of the next Plan Year.

The Employer may, in lieu of a Salary Reduction Agreement, provide an electronic method for Employees to use to make elections. The Employer may require Employees to use the electronic system to make elections. Use of an electronic system will have the same effect as a signed Salary Reduction Agreement.

**5.3 Failure To Elect**

If an Employee fails to complete, sign and return a Salary Reduction Agreement or fails to complete an election using the electronic system (if any) provided by the Employer within the time described in the Elections paragraphs as discussed immediately above, then the Employee will be deemed to have elected to receive his or her entire Compensation in cash (excluding the PPP). The Employer provides for an automatic election for the PPP, therefore, the Employee will have also agreed to a Salary Reduction for such Employee's Contribution to the PPP.

Such Employee may not enroll in the Plan:

- Until the next Open Enrollment Period; or

- **Until an event occurs that would justify a mid-year election change as described in the Irrevocability of Election and Exceptions section below.**

**Section 6**  
**Irrevocability of Elections and Exceptions**

**6.1 Irrevocability of Elections**

A Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates, except as described in this Section.

The irrevocability rules do not apply to the HSA Contribution Benefit election.

The rules regarding irrevocability of elections and exceptions are quite complex. The Plan Administrator will interpret these rules in accordance with prevailing IRS guidance.

**6.2 Procedure for Making New Election If Exception to Irrevocability Applies**

- **Timing for Making New Election if Exception to Irrevocability Applies.** A Participant may make a new election within 30 days of the occurrence of an event described in section 6.4 below, if the election under the new Salary Reduction Agreement is made on account of and corresponds to the event. A Change in Status, as defined below, that automatically results in ineligibility in the Health Plan shall automatically result in a corresponding election change, whether or not requested.
- **Effective Date of New Election.** Elections made pursuant to this Section shall be effective on the 1st of the month following or coinciding with the Plan Administrator's receipt and approval of the election request for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in "Certain Judgments, Decrees and Orders" or for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only.
- **Changes.** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Salary Reduction Agreement or other document.
- **Effect on Maximum Benefits.** Any change in an election affecting annual Contributions to the Health FSA or DCAP also will change the maximum reimbursement Benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement Benefits for the balance of the Period of Coverage shall be calculated by adding:
  - Any Contributions made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election; to
  - The total Contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Benefit Option; reduced by
  - All reimbursements made during the entire Period of Coverage.

### 6.3 Change in Status Defined

A Participant may make a new election that corresponds to a gain or loss of eligibility and coverage under this Plan or under any other plan maintained by the Employer or a plan of the Spouse's or Dependent's employer that was caused by the occurrence of a Change in Status. A Change in Status is any of the events described below, as well as any other events included under subsequent changes to Code §125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

- **Legal Marital Status.** A change in a Participant's legal marital status including marriage, death of a Spouse, divorce, legal separation or annulment;
- **Number of Dependents.** Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption. In the case of the DCAP, a change in the number of Qualifying Individuals as defined in Code §21(b)(1);
- **Employment Status.** Any of the following events that change the employment status of the Participant, Spouse or Dependents:
  - A termination or commencement of employment;
  - A commencement of or return from an unpaid leave of absence;
  - A change in worksite; or
  - If the eligibility conditions of this Plan or another employee benefit plan of the Participant, Spouse or Dependent depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes, or ceases to be, eligible under this Plan or another employee benefit plan;
- **Dependent Eligibility Requirements.** An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular Benefit; and
- **Change in Residence.** A change in the place of residence of the Participant, Spouse or Dependent(s).

### 6.4 Events Permitting Exception to Irrevocability Rule

A Participant may change an election as described below upon the occurrence of the stated events for the applicable Benefit Option.

The following rules shall apply to all Benefit Options except where expressly limited below.

- **Open Enrollment Period.** A Participant may change an election during the Open Enrollment Period.

- **Termination of Employment.** A Participant's election will terminate upon termination of employment as described in the Eligibility and Participation section above.
- **Leave of Absence.** A Participant may change an election upon a leave of absence as described in the Eligibility and Participation section above.
- **Change in Status.** *(Applies to the PPP, Health FSA, and DCAP as limited below.)* A Participant may change the actual or deemed election under the Plan upon the occurrence of a Change in Status, but only if such election change corresponds with a gain or loss of eligibility and coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer, referred to as the general consistency requirement.

A Change in Status that affects eligibility for coverage also includes a Change in Status that results in an increase or decrease in the number of an Employee's family members who may benefit from the coverage.

The Plan Administrator, on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change satisfies the general consistency requirement. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter elections based on the specified Change in Status:

- **Loss of Spouse or Dependent Eligibility.** For a Change in Status involving a Participant's divorce, annulment or legal separation, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel health plan coverage and deduction plans offered under the Voluntary Payroll Vendors for:
  - The Spouse involved in the divorce, annulment, or legal separation;
  - The deceased Spouse or Dependent; or
  - The Dependent that ceased to satisfy the eligibility requirements.

Canceling coverage for any other individual under these circumstances fails to correspond with that Change in Status.

Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA or similar health plan continuation coverage under the Employer's plan, then the Participant may increase his or her election to pay for such coverage. This rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation.

- **Gain of Coverage Eligibility Under Another Employer's Plan.** When a Participant, Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of that Participant's Spouse or Dependent, a Participant may elect to terminate or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has

obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

- **Special Consistency Rule for DCAP Benefits.** With respect to the DCAP, the Participant may change or terminate the Participant's election upon a Change in Status if:
  - Such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an Employer's plan; or
  - The election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code §129.
- **HIPAA Special Enrollment Rights (*Applies to the PPP only*).** If the Participant, the Participant's Spouse or Dependent is entitled to special enrollment rights under a group health plan as required by HIPAA, then the Participant may revoke a prior election for group health plan coverage and make a new election provided that the election change corresponds with such HIPAA special enrollment right. As more specifically defined by HIPAA, a special enrollment right will arise in the following circumstances:
  - The Participant, Spouse or Dependent declined to enroll in group health plan coverage because the Participant, the Participant's Spouse or Dependent had coverage, and eligibility for such coverage is subsequently lost because the coverage was provided under COBRA and the COBRA coverage was exhausted; or the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated;
  - The Participant acquired a new Dependent as a result of marriage, birth, adoption or placement for adoption; or
  - The Employee or Dependents who are eligible but did not enroll for coverage when initially eligible and:
    - The Employee or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or
    - The Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, and the employee requests coverage under the Plan within 60 days after eligibility is determined.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change due to birth, adoption, or placement for adoption of a new Dependent child may, subject to the group health plan, be effective retroactively for up to 30 days.

- **Certain Judgments, Decrees and Orders. (*Applies to the PPP, Health FSA, but does not apply to the DCAP*).** If a judgment, decree, or order resulting from a divorce, legal separation,



annulment or change in legal custody, including a Qualified Medical Child Support Order (QMCSO) requires accident or health coverage, including an election for Health FSA Benefits for a Participant's Dependent child, a Participant may:

- Change an election to provide coverage for the Dependent child provided that the order requires the Participant to provide coverage; or
- Change an election to revoke coverage for the Dependent child if the order requires that another individual provide coverage under that individual's plan and such coverage is actually provided.
- **Medicare and Medicaid.** *(Applies to the PPP, Health FSA, but does not apply to the DCAP).* If a Participant, Spouse or Dependent is enrolled in a Benefit under this Plan and becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the Health Plan covering the person, and the Health FSA coverage may be cancelled but not reduced. However, such cancellation will not be effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Further, if a Participant, Spouse, or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the Health FSA coverage.
- **Change in Cost.** *(Applies to the PPP and DCAP as limited below, but does not apply to the Health FSA).* For purposes of this Section, "similar coverage" means coverage for the same category of Benefits for the same individuals.
  - **Insignificant Cost Changes.** The Participant is required to increase his or her elective Contributions to reflect insignificant increases in the required Contribution for the Benefit Options, and to decrease the elective Contributions to reflect insignificant decreases in the required Contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically make this increase or decrease in affected Participants' elective Contributions on a prospective basis.
  - **Significant Cost Increases.** If the Plan Administrator determines that the cost charged to an Employee for a Benefit significantly increases during a Period of Coverage, the Participant may:
    - Make a corresponding prospective increase to elective Contributions by increasing Salary Reductions;
    - Revoke the election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Option that provides similar coverage; or
    - Terminate coverage going forward if there is no other Benefit Option available that provides similar coverage.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant.

- **Significant Cost Decreases.** If the Plan Administrator determines that the cost of any Benefit (such as the premium for the Health Plan) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes:
  - Participants enrolled in that Benefit Option may make a corresponding prospective decrease in their elective contributions by decreasing Salary Reductions;
  - Participants who are enrolled in another benefit package option may change their election on a prospective basis to elect the Benefit Option that has decreased in cost; or
  - Employees who are otherwise eligible may elect the Benefit Option that has decreased in cost on a prospective basis, subject to the terms and limitations of the Benefit Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant.
- **Limitation on Change in Cost Provisions for DCAP Benefits.** The above "Change in Cost" provisions apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a relative of the Employee.
- **Change in Coverage.** (*Applies to the PPP and DCAP, but not to the Health FSA*). The definition of "similar coverage" applied in the Change of Cost provision above also applies here.
  - **Significant Curtailment.** Coverage under a Plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the Plan to constitute reduced coverage generally. If coverage is "significantly curtailed," Participants may elect coverage under a Benefit Option that provides similar coverage. In addition, if the coverage curtailment results in a "Loss of Coverage" as defined below, Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a curtailment is "significant," and whether a Loss of Coverage has occurred in accordance with prevailing IRS guidance.
    - **Significant Curtailment Without Loss of Coverage.** If the Plan Administrator determines that a Participant's coverage under a Benefit Option (or the Participant's, Spouse's or Dependent's coverage under the respective employer's plan) is significantly curtailed without a Loss of Coverage during a Period of Coverage, the Participant may revoke an election for the affected coverage and prospectively elect coverage under another Benefit Option if offered, that provides similar coverage.
    - **Significant Curtailment With a Loss of Coverage.** If the Plan Administrator determines that a Participant's coverage under this Plan (or the Participant's, Spouse's or Dependent's coverage under the respective employer's plan) is significantly curtailed, and such curtailment results in a Loss of Coverage during a Period of Coverage, the Participant may revoke an election for the affected coverage, and may either prospectively elect coverage under another Benefit Option that provides similar

coverage or drop coverage if no other Benefit Option providing similar coverage is offered by the Employer.

- **Definition of Loss of Coverage.** For purposes of this Section, a "Loss of Coverage" means a complete loss of coverage. In addition, the Plan Administrator in its sole discretion and on a uniform and consistent basis, may treat the following as a Loss of Coverage:
  - A substantial decrease in the health care providers available under the Benefit Package Plan;
  - A reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or
  - Any other similar fundamental loss of coverage.
- **Addition or Significant Improvement of a Benefit Option.** If during a Period of Coverage, the Plan adds a new Benefit Option or significantly improves an existing Benefit Option, the Plan Administrator may permit the following election changes:
  - Participants who are enrolled in a Benefit Option other than the newly-added or significantly improved Benefit Option that provides similar coverage may change their election on a prospective basis to cancel the current Benefit Option and instead elect the newly added or significantly improved Benefit Option; and
  - Employees who are otherwise eligible may elect the newly added or significantly improved Benefit Option on a prospective basis, subject to the terms and limitations of the Benefit Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Option.
- **Loss of Coverage Under Another Group Health Coverage.** A Participant may prospectively change an election to add group health coverage for the Participant, Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including, but not limited to, the following:
  - A children's health insurance program (CHIP) under Title XXI of the Social Security Act;
  - A health care program of an Indian Tribal government (as defined in Code §7701(a)(40)), the Indian Health Service, or a tribal organization;
  - A state health benefits risk pool; or
  - A foreign government group health plan, subject to the terms and limitations of the applicable Benefit Option.

- **Change in Coverage Under Another Employer Plan.** A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan, including a plan of the Employer or a plan of the Spouse's or Dependent's employer, so long as:
  - The other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or
  - The Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan.

The Plan Administrator, on a uniform and consistent basis, will decide whether a requested change is because of, and corresponds with, a change made under the other employer plan.

- **Change in Dependent Care Service Provider.** A Participant may make a prospective election change that corresponds with a change in the dependent care service provider. For example:
  - If the Participant terminates one dependent care service provider and hires a new dependent care service provider, the Participant may change coverage to reflect the cost of the new service provider; and
  - If the Participant terminates a dependent care service provider because a relative or other person becomes available to take care of the child at no charge, the Participant may cancel coverage.

A Participant entitled to change an election as described in this Section must do so in accordance with the procedures described this Section.

#### **6.5 Election Modifications for HSA Contribution Benefits May be Changed Prospectively At Any Time**

As set forth in Schedule C, an election to make a Contribution to an HSA Contribution Benefit can be increased, decreased or revoked at any time on a prospective basis. Such election changes shall be effective no later than the 1<sup>st</sup> day of the next calendar month following the date that the election change was filed. No other Benefit Option election changes can occur as a result of a change in an HSA Contribution Benefit election except as otherwise permitted in this Section.

A Participant entitled to change an election as described in this Section must do so in accordance with the procedures described above.

#### **6.6 Election Modifications Required by Plan Administrator**

The Plan Administrator may require, at any time, any Participant or class of Participants to amend their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to:

- Satisfy any of the Code's nondiscrimination requirements applicable to this Plan or another cafeteria plan;
- Prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of Benefits hereunder than would otherwise be recognized;
- Maintain the qualified status of Benefits received under this Plan; or
- Satisfy any of the Code's nondiscrimination requirements or other limitations applicable to the Employer's qualified Plans.

In the event that Contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount, and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

**Section 7  
Claims and Appeals****7.1 Claims Under the Plan**

If a claim for reimbursement under the Health FSA or DCAP is wholly or partially denied, or if the Participant is denied a Benefit under the Plan regarding the Participant's coverage under the Plan, then the claims procedure described below will apply.

**7.2 Notice from ASI**

If a claim is denied in whole or in part, ASI will notify the Participant in writing within 30 days of the date that ASI received the claim. This time may be extended for an additional 15 days for matters beyond the control of ASI, including cases where a claim is incomplete. ASI will provide written notice of any extension, including the reason(s) for the extension and the date a decision by ASI is expected to be made. When a claim is incomplete, the extension notice will also specifically describe the required information, and will allow the Participant at least 45 days from receipt of the notice to provide the specified information, and will have the effect of suspending the time for a decision on the claim until the specified information is provided. Notification of a denied claim will include:

- The specific reasons for the denial;
- The specific Plan provisions on which the denial is based;
- A description of any additional material or information necessary to validate the claim and an explanation of why such material or information is necessary; and
- Appropriate information on the steps to take to appeal ASI's adverse benefits determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information, and the right to file suit, where applicable, with respect to any adverse benefits determination after the final appeal of the claim.

**7.3 First Level Appeal to ASI**

If a claim is denied in whole or in part, the Participant, or the Participant's authorized representative, may request a review of the adverse benefits determination upon written application to ASI. The Participant, or the Participant's authorized representative, may request access to all relevant documents in order to evaluate whether to request review of an adverse benefits determination and, if review is requested, to prepare for such review.

An appeal of an adverse benefits determination must be made in writing within 90 days upon receipt of the notice that the claim was denied. If an appeal is not made within the above referenced timeframe all rights to appeal the adverse benefits determination and to file suit in court will be forfeited unless otherwise protected by law. A written appeal should include: additional documents, written comments, and any other information in support of the appeal. The review of the adverse benefits determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.



#### **7.4 ASI Action on Appeal**

ASI, within a reasonable time, but no later than 60 days after receipt of the request for review, will decide the appeal. ASI may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reasons for the decision on review;
- The specific Plan provisions on which the decision is based;
- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If an internal rule, guideline, protocol, or other similar criterion is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and
- Appropriate information on the steps to take to appeal ASI's adverse benefits determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information, and the right to file suit, where applicable, with respect to any adverse benefits determination after the final appeal of the claim.

#### **7.5 Second and Final Level Appeal to the Plan Administrator**

If the decision on review affirms ASI's initial denial, the Participant may request a review of the adverse appeal determination upon written application to the Plan Administrator.

The Participant, or the Participant's authorized representative, may request access to all relevant documents in order to evaluate whether to request review of an adverse benefits determination and, if review is requested, to prepare for such review.

An appeal of an adverse appeal determination must be made in writing within 30 days after receipt of the notice that the first level appeal was denied. If an appeal is not made within the above referenced timeframe all rights to appeal the adverse benefits determination and to file suit in court will be forfeited unless otherwise protected by law. A written appeal should include: additional documents, written comments, and any other information in support of the appeal. The review of the adverse benefits determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the prior determination.

#### **7.6 Plan Administrator Action on Appeal**

The Plan Administrator, within a reasonable time, but no later than 60 days after receipt of the request for review, will decide the appeal. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the prior claim denial.

The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reason(s) for the decision on review;
- The specific Plan provision(s) on which the decision is based;
- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If an internal rule, guideline, protocol, or other similar criterion is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request.

#### 7.7 Appeal Procedure for Eligibility or Salary Reduction Issues

If the Participant is denied a Benefit under the Plan due to questions regarding the Participant's eligibility or entitlement for coverage under the Plan or regarding the amount the Participant owes, the Participant may request a review upon written application to the Plan Administrator.

The Participant, or the Participant's authorized representative, may request access to all relevant documents in order to evaluate whether to request review of an adverse benefits determination and if review is requested, to prepare for such review.

An appeal of an adverse benefits determination must be made in writing within 180 days upon receipt of the notice that the claim was denied. If an appeal is not made within the above referenced timeframe all rights to appeal the adverse benefits determination and to file suit in court will be forfeited unless otherwise protected by law. A written appeal should include: additional documents, written comments, and any other information in support of the appeal. The review of the adverse benefits determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The Plan Administrator, within a reasonable time, but no later than 30 days after receipt of the request for review, will decide the appeal. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reasons for the decision on review;
- The specific Plan provisions on which the decision is based;
- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and



- **Appropriate information on the steps to take to appeal the Plan Administrator's adverse benefits determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information, and the right to file suit, where applicable, with respect to any adverse benefits determination after the final appeal of the claim.**

**If the decision on review affirms the Plan Administrator's denial, the Participant may request a review of the adverse appeal determination upon written application to the Plan Administrator. The Second and Final Level of Appeals Procedures described above will apply.**

**Section 8  
Plan Administration****8.1 Plan Administrator**

The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out in accordance with the terms of the Plan document and for the exclusive benefit of persons entitled to participate in this Plan and without discrimination among them.

**8.2 Powers of the Plan Administrator**

The Plan Administrator shall have such powers and duties as may be necessary or appropriate to discharge its functions hereunder. The Plan Administrator shall have final discretionary authority to make such decisions and all such determinations shall be final, conclusive and binding. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters hereunder. The Plan Administrator shall have the following discretionary authority:

- To construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of Benefits under this Plan (provided that the Plan Administrator shall exercise such exclusive power with respect to an appeal of a claim);
- To prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;
- To prepare and distribute information explaining this Plan and the Benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;
- To request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;
- To furnish each Employee and Participant with such reports in relation to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide Benefits under this Plan;
- To receive, review and keep on file such reports and information concerning the Benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;
- To appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and Benefit consultants;
- To sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

- To secure independent medical or other advice and require such evidence as deemed necessary to decide any claim or appeal; and
- To maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

#### **8.3 Reliance on Participant, Tables, etc.**

The Plan Administrator may rely upon the Participant's direction, information or election as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by the Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

#### **8.4 Outside Assistance**

The Plan Administrator may employ such counsel, accountants, claims administrators, consultants, actuaries and other person or persons as the Plan Administrator shall deem advisable. The Plan shall pay the compensation of such counsel, accountants, and other person or persons and any other reasonable expenses incurred by the Plan Administrator in the administration of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligations of the Employer and the Plan Administrator.

#### **8.5 Insurance Contracts**

The Employer and/or some of the related employers adopting this Plan may have the right to enter into a contract with one or more insurance companies or self-fund for the purposes of providing any Benefits under the Plan; and to replace any of such insurance companies, contracts, or benefits. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer Contributions toward such insurance.

#### **8.6 Fiduciary Liability**

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act.

#### **8.7 Inability to Locate Payee**

If the Plan Administrator is unable to make payment to the Participant or another person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of the Participant or such other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to the Participant or such other person shall be forfeited one year after the date any such payment first became due.

**8.8 Effect of Mistake**

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the Participant's account, or the amount of Benefits paid or to be paid to the Participant or another person, the Plan Administrator shall, to the extent administratively possible and otherwise permissible under Code §125 or the regulations issued thereunder, correct by making the appropriate adjustments of such amounts as necessary to credit the Participant's account or such other person's account or withhold any amount due to the Plan or the Employer from Compensation paid by the Employer.

Section 9  
**Amendment or Termination of the Plan**

**9.1 Permanency**

While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in the paragraphs below.

**9.2 Right to Amend**

The Employer reserves the right to merge or consolidate the Plan and to make any amendment or restatement to the Plan from time-to-time, including those which are retroactive in effect. Such amendments may be applicable to any Participant.

Any amendment or restatement shall be deemed to be duly executed when properly promulgated in accordance with ~~under the requirements of~~ Chapter 536.

**9.3 Right to Terminate**

The Plan Administrator reserves the right to discontinue or terminate the Plan in whole or in part at any time without prejudice. A related employer has the right to discontinue participating in the Plan at the end of each calendar year.

**Section 10  
General Provisions****10.1 No Contract of Employment**

Nothing contained in the Plan shall be construed as a contract of employment with the Employer or as a right of any Employee to be continued in the employment of the Employer, or as a limitation of the right of the Employer to discharge any Employee, with or without cause.

**10.2 Compliance with Federal Mandates**

To the extent applicable for each Benefit Option, the Plan will provide Benefits in accordance with the requirements of all federal mandates, including USERRA, COBRA, and HIPAA. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

**10.3 Verification**

The Plan Administrator shall be entitled to require reasonable information to verify any claim or the status of any person as an Employee or Dependent. If the Participant does not supply the requested information within the applicable time limits or provide a release for such information, the Participant will not be entitled to Benefits under the Plan.

**10.4 Limitation of Rights**

Nothing appearing in or done pursuant to the Plan shall be held or construed:

- To give any person any legal or equitable right against the Employer, any of its employees, or persons connected therewith, except as provided by law; or
- To give any person any legal or equitable right to any assets of the Plan or any related trust, except as expressly provide herein or as provided by law.

**10.5 Non-Assignability of Rights**

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

**10.6 Governing Law**

This Plan is intended to be construed, and all rights and duties hereunder are governed, in accordance with the laws of the State of Missouri, except to the extent such laws are preempted by any federal law.

**10.7 Severability**

If any provision of the Plan is held invalid or unenforceable, its validity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

**10.8 Captions**

The captions contained herein are inserted only as a matter of convenience and for reference and in no way define, limit, enlarge or describe the scope or intent of the Plan nor in any way shall affect the Plan or the construction of any provision thereof.

**10.9 Federal Tax Disclaimer**

To ensure compliance with requirements imposed by the IRS to the extent this Plan Document or any Schedule contains advice relating to a federal tax issue, it is not intended or written to be used, and it may not be used, for the purpose of avoiding any penalties that may be imposed on the Participant or any other person or entity under the Internal Revenue Code or promoting, marketing or recommending to another party any transaction or matter addressed herein.

**10.10 No Guarantee of Tax Consequences**

Neither the Plan Administrator nor the Employer make any commitment or guarantee that any amounts paid to the Participant or for the Participant's benefit under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the Participant's obligation to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

**10.11 Indemnification of Employer**

If the Participant receives one or more payments or reimbursements under this Plan on a pre-tax Salary Reduction basis, and such payments do not qualify for such treatment under the Code, the Participant shall indemnify and reimburse the Employer for any liability the Employer may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

**Section 11  
HIPAA Privacy and Security****11.1 Provision of Protected Health Information to Employer**

For purposes of this Section, Protected Health Information (PHI) shall have the meaning as defined in HIPAA. PHI means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. PHI includes information of persons living or deceased.

Members of the Employer's workforce have access to the individually identifiable health information of Plan Participants for administrative functions of the Health FSA, plus any other Benefit Option which might be subject to the privacy and security provisions of HIPAA (hereinafter referred to collectively as the Plan). When this health information is provided to the Employer, it is PHI. HIPAA and its implementing regulations restrict the Employer's ability to use and disclose PHI. The Employer shall have access to PHI from the Plan only as permitted under this Section or as otherwise required or permitted by HIPAA.

**11.2 Permitted Disclosure of Enrollment/Disenrollment Information**

The Plan Administrator or ASI may disclose to the Employer information on whether the individual is participating in the Plan.

**11.3 Permitted Uses and Disclosure of Summary Health Information**

The Plan may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

Summary Health Information means information:

- That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and
- From which the required information has been deleted, except that the geographic information need only be aggregated to the level of a five-digit ZIP code.

**11.4 Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes**

Unless otherwise permitted by law, and subject to the conditions of disclosure and obtaining written certification described below, the Plan may disclose PHI to the Employer, provided that the Employer uses or discloses such PHI only for Plan Administration Purposes.

Plan Administration Purposes means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan Administration functions do not include functions performed by the Employer in connection with any



other benefit or benefit plan of the Employer, and they do not include any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

#### **11.5 Conditions of Disclosure for Plan Administration Purposes**

Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it, the Employer shall:

- Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
- Not use or disclose the PHI for employment-related actions and decisions;
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance with HIPAA's privacy and security requirements;
- If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that the adequate separation between the Plan and the Employer (i.e., the "firewall"), required in 45 CFR §504(f)(2)(iii), is satisfied.

The Employer further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not

subject to these restrictions) on behalf of the Plan, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents, including subcontractors, to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Plan any security incident of which it becomes aware.

#### 11.6 Adequate Separation Between Plan and Employer

The Employer shall designate such employees of the Employer who need access to PHI in order to perform Plan administration functions that the Employer performs for the Plan such as quality assurance, auditing, monitoring, payroll, and appeals. No other persons shall have access to PHI. These specified employees, or classes of employees, shall only have access to and use of PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Plan.

In the event that any of these designated employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

The Employer will ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

#### 11.7 Certification of Plan Sponsor

The Plan shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth under the section entitled *Conditions of Disclosure for Plan Administration Purposes*.

#### 11.8 Organized Health Care Arrangement

The Plan Administrator intends the Plan to form part of an Organized Health Care Arrangement along with any other Benefit Option under a covered health plan under 45 CFR §160.103 provided by Employer.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the State of Missouri Cafeteria Plan, State of Missouri has caused this Plan to be executed in its name and on its behalf, on this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

State of Missouri

By: \_\_\_\_\_

Its: \_\_\_\_\_

Attest: \_\_\_\_\_

Its: \_\_\_\_\_

**Glossary**

Capitalized terms used in the Plan have the following meanings:

**Account** means the account(s) maintained under this Cafeteria Plan by the Plan Administrator to which allocations of employer contributions are made for each participant as required by this Cafeteria Plan and from which payments, as permitted by this Cafeteria Plan, shall be paid.

**Benefit or Benefits** means the Benefit Options offered under the Plan.

**Benefit Option** means a qualified benefit under Code §125(f) that is offered under this Cafeteria Plan, or an option for coverage under an underlying accident or health plan.

**Cafeteria Plan** means the State of Missouri Cafeteria Plan as set forth herein and as amended from time to time.

**Claims Administrator** means Application Software, Inc., dba ASI, dba ASIFlex.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**Code** means the Internal Revenue Code of 1986, as amended.

**Compensation** means the wages or salary paid to an Employee by the Employer, determined prior to: any Salary Reduction election under this Plan; any Salary Reduction election under any other cafeteria plan; any compensation reduction under any Code §132(f)(4) plan; and any salary deferral elections under any Code §§401(k), 408(k) or 457(b) Plan or arrangement.

**Contribution** means the amount contributed to pay for the cost of Benefits as calculated under the Benefit Options.

**DCAP** means Dependent Care Assistance Program.

**Dependent** means any individual who is a tax dependent of the Participant as defined in Code §§105(b) and 152, with the following exceptions:

- For purposes of accident or health coverage (to the extent funded under the PPP, and for purposes of the Health FSA:
  - A dependent is defined as in Code §§105(b) and 152, determined without regard to §152 subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and
  - Any child whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year) is treated as a dependent of both parents; and
- For purposes of the DCAP, a dependent means a Qualifying Individual.

**Notwithstanding the foregoing, the Health FSA Component will provide Benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."**

**Dependent Care Assistance Program means the dependent care assistance program component established by Employer under the Plan. It allows the Participant to use pre-tax dollars to pay for the care of the Participant's eligible Dependents while the Participant is at work.**

**Dependent Care Expenses has the meaning described in the DCAP Schedule below.**

**Earned Income means all income derived from wages, salaries, tips, self-employment, and other compensation (such as disability or wage continuation Benefits), but only if such amounts are includible in gross income for the taxable year. Earned income does not include: any amounts received pursuant to any DCAP established under Code §129; or any other amounts excluded from earned income under Code §32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.**

**Effective Date of this Plan shall be January 1, 2011.**

**Employee means any person employed by the employer.**

**The following classes of employees cannot participate in the State of Missouri Cafeteria Plan:**

- **Leased employees (as defined by §414 (n) of the Code);**
- **Contract workers and independent contractors; and**
- **Individuals paid by a temporary or other employment or staffing agency.**

**Employer means State of Missouri including any agency, or department of the State of Missouri other than the University of Missouri and Southeast Missouri State University.**

**ERISA means the Employee Retirement Income Security Act of 1974, as amended.**

**FMLA means the Family and Medical Leave Act of 1993, as amended.**

**HDHP means High Deductible Health Plan.**

**Health Care Expenses has the meaning defined in the Health FSA Schedule below.**

**Health Flexible Spending Account means the health flexible spending account component established by the Employer under the Plan. It allows a Participant to use pre-tax dollars to pay for most health and dental expenses not reimbursed under other programs.**

**Health FSA means Health Flexible Spending Account.**

**Health Plan means the health benefit plan sponsored by the Employer.**

**Health Savings Account means the savings account Benefit Option established by the Employer's designee under this Plan.**

**High Deductible Health Plan** means the high deductible health plan offered by the Employer that is intended to qualify as a high deductible health plan under Code §223(c)(2), as described in materials provided separately by the Employer.

**HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as amended.

**HSA** means a Health Savings Account established under Code §223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee/custodian.

**HSA Contribution Benefit** means the election to allow an Employee to receive HSA Contributions on a pre-tax, Salary Reduction basis and such Employer Contributions are excludable from the HSA Employee's income.

**HSA Employee** means an Employee covered under a qualifying High Deductible Health Plan (HDHP) (as defined by IRC §223). In order to receive Employer HSA Contribution Benefit, the Employee must certify that he or she: cannot be claimed as another person's tax dependent; is not entitled to Medicare Benefits, and does not have any health coverage other than HDHP coverage.

**Office of Administration** means the Office of Administration of the State of Missouri.

**Open Enrollment Period** with respect to a Plan Year means a period as described by the Plan Administrator preceding the Plan Year during which Participants may make Benefit elections for the Plan Year.

**Participant** means a person who is an Employee and who is participating in this Plan in accordance with the provisions of the Eligibility and Participation Section. Participants include: (a) those that elect to receive Benefits under this Plan, and enroll for Salary Reductions to pay for such Benefits; and (b) those that elect instead to receive their full salary in cash and have not elected the Health FSA or DCAP.

**Period of Coverage** means the Plan Year, with the following exceptions: for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in the Eligibility and Participation Section; and for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in the Eligibility and Participation Section.

**PHI** means Protected Health Information.

**Plan** means the State of Missouri Cafeteria Plan, as set forth herein and as amended from time to time.

**Plan Administrator** means the Office of Administration or its duly appointed designee to administer this Cafeteria Plan.

**Plan Year** means the twelve-month period ending December 31.

**PPP** means the Premium Payment Plan.

**Premium Payment Plan** means the Benefit Option in which an Employee can elect to participate and have Contributions for the Health Plan paid on a pre-tax basis.

**Protected Health Information (PHI)** means information that is created or received by State of Missouri Cafeteria Plan and relates to the past, present, or future physical, mental health or condition of a Participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. Protected health information includes information of persons living or deceased.

**QMCSO** means a Qualified Medical Child Support Order, as defined in ERISA §609(a).

**Qualifying Dependent Care Services** has the meaning described in the DCAP Schedule below.

**Qualifying Individual** means:

- A tax dependent of the Participant as defined in Code §152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code § 152(a)(1);
- A tax dependent of the Participant as defined in Code §152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or
- A Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child shall, as provided in Code §21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code §152(e)) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

**Related Employer** means any employer affiliated with State of Missouri that, under Code §414(b), (c), or (m), is treated as a single employer with State of Missouri for purposes of Code §125(g)(4), and which is listed in Appendix B.

**Salary Reduction** means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefit Options.

**Salary Reduction Agreement** means the agreement, form(s) or Internet web site, which Employees use to elect one or more Benefit Options. The agreement, forms and/or Internet web site spell out the procedures used for allowing an Employee to participate in this Plan and will allow the Employee to elect Salary Reductions to pay for any Benefit Options offered under this Plan.

**Spouse** means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a Spouse under the Code). Notwithstanding the above, for purposes of the DCAP, the term "Spouse" shall not include: an individual legally separated from the Participant under a divorce or separate maintenance decree; or an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from

the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

**Student** means an individual who, during five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly held.

**USERRA** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

**Waive coverage** means to formally opt-out of participation in the PPP in writing or online.



**Appendix A**  
**Exclusions—Medical Expenses That Are Not Reimbursable From the Health FSA**

The Plan Document contains the general rules governing what expenses are reimbursable under the Health FSA. This Appendix A, as referenced in the Plan Document, specifies certain expenses that are excluded under this Plan with respect to reimbursement from the Health FSA -- that is, expenses that are *not* reimbursable, even if such expenses meet the definition of "medical care" under Code §§213(d) and 106(f) and may otherwise be reimbursable under the regulations governing health flexible spending accounts:

- Health insurance premiums for any other plan (including a plan sponsored by the Employer).
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).
- Custodial care.
- Costs for sending a problem child to a special school for Benefits that the child may receive from the course of study and disciplinary methods.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Over-the-counter medications and drugs, excluding insulin, without proof of a valid prescription.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.

- Any item that does not constitute “medical care” as defined under Code §§213(d) and 106(f).
- Any item that is not reimbursable under Code §§213(d) and 106(f) due to the rules in Prop. Treas. Reg. §1.125-2, Q-7(b)(4) or other applicable regulations.

**Appendix B**  
**Related Employers That Have Adopted This Plan**

**With the Approval of State of Missouri.**

**The following Related Employers have adopted this plan:**

- **The Office of Administration**
- **The Department of Agriculture**
- **The Department of Conservation**
- **The Department of Corrections**
- **The Department of Economic Development**
- **The Department of Elementary and Secondary Education**
- **The Department of Health and Senior Services**
- **The Department of Higher Education**
- **The Department of Insurance, Financial Institutions and Professional Registration**
- **The Department of Labor and Industrial Relations**
- **The Department of Mental Health**
- **The Department of Natural Resources**
- **The Department of Public Safety**
- **The Department of Revenue**
- **The Department of Social Services**
- **The Department of Transportation**
- **The Office of the Attorney General**
- **The Office of the Governor**
- **The Office of the Lieutenant Governor**
- **The Office of the State Auditor**
- **The Office of the Secretary of State**
- **The Office of the Treasurer**
- **The Missouri House of Representatives**
- **The Missouri Senate**
- **The Missouri Consolidated Health Care Plan**
- **The Missouri State Employees' Retirement System**
- **The Supreme Court**
- **Harris-Stowe State University Board of Regents**
- **Lincoln University Board of Curators**
- **Missouri State University**
- **Northwest Missouri State University Board of Regents**
- **Truman State University Board of Governors**
- **University of Central Missouri Board of Governors**

**Employer means State of Missouri including any agency, or department of the State of Missouri other than the University of Missouri and Southeast Missouri State University.**

**Schedule A**  
**Premium Payment Plan**

Unless otherwise specified, terms capitalized in this Schedule A shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

**A.1 Benefits**

If the Employee is an enrolled participant in the Health Plan and timely submits an executed Salary Reduction Agreement, the Employee can either:

- Option A: Elect Benefits under the PPP by electing to contribute his or her share for the Health Plan on a pre-tax basis; or
- Option B: Elect no Benefits under the PPP and to contribute his or her share, if any, for the Health Plan with after-tax deductions outside of this Plan.

If the Employee is an enrolled participant in the Health Plan and/or deduction plans of the Voluntary Payroll Vendors and does not timely submit an executed Salary Reduction Agreement, the Employee will be deemed to have elected Option A.

Benefits elected under Option A will be funded by the Participant's Contributions as provided in the Eligibility and Participation section in the Plan Document.

To determine when a Salary Reduction Agreement will be considered timely submitted, see the Method and Timing of Elections section in the Plan Document.

Unless an exception applies, as described in the Irrevocability of Elections and Exceptions section in the Plan Document, such election is irrevocable for the duration of the Period of Coverage to which it relates.

**A.2 Benefit Contributions**

The annual Contribution for the PPP is equal to the amount as set by the Employer, which may or may not be the same amount charged under the Health Plans.

**A.3 Medical Benefits Provided Under the Health Plans**

Medical benefits will be provided by the Health Plans, not this Plan. The types and amounts of medical benefits, the requirements for participation, and other terms and conditions of coverage and benefits of the Health Plans are set forth in the documents relating to that plan. No changes can be made under this Plan with respect to such Health Plans if such changes are not permitted under the applicable Health Plans.

All claims to receive benefits under the Health Plans shall be subject to and governed by the terms and conditions of the Health Plans and the rules, regulations, policies and procedures adopted in accordance therewith, as may be amended from time to time.

**A.4 COBRA**

To the extent required by COBRA, the Participant, Spouse and Dependent, as applicable, whose coverage terminates under the Health Plan because of a COBRA qualifying event and who is a qualified beneficiary as defined under COBRA, shall be given the opportunity to continue the same coverage that the Participant, Spouse or Dependent had under the Health Plan the day before the qualifying event for the periods prescribed by COBRA, on a self-pay basis. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

**A.5 Deduction Plans Provided Under the Voluntary Payroll Vendors**

Voluntary payroll vendors must qualify for inclusion in this Plan under rules set forth in 1 CSR 10-15.010 and 1 CSR 10-4.010 in order for the vendors' products to be included within this Plan.

Deduction plans provided by the Voluntary Payroll Vendors are offered by such vendors, not this Plan. The types and amounts of benefits, the requirements for participation, and other terms and conditions of coverage and benefits of the plans provided by the Voluntary Payroll Vendors are set forth in the documents relating to those plans. No changes can be made under this Plan with respect to such plans if such changes are not permitted under the applicable plans. In addition, no changes may also be made under this Plan unless such changes are permitted by this Plan.

All claims to receive benefits under the plans provided by the Voluntary Payroll Vendors shall be subject to and governed by the terms and conditions of such plans and the rules, regulations, policies and procedures adopted in accordance therewith, as may be amended from time to time.

**Schedule B**  
**Health Flexible Spending Account**

Unless otherwise specified, terms capitalized in this Schedule B shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

**B.1 Benefits**

An Employee not enrolled in the HSA Contribution Benefit, can elect to participate in the Health FSA by electing to receive Benefits in the form of reimbursements for Health Care Expenses. If elected, the Benefit Option will be funded by Participant Contributions on a pre-tax Salary Reduction basis as provided in the Employer and Participant Contributions section in the Plan Document.

Unless an exception applies as described in the Irrevocability of Elections and Exceptions section, such election is irrevocable for the duration of the Period of Coverage to which it relates.

The HSA Contribution Benefit cannot be elected with the Health FSA. In addition, a Participant who has an election for the Health FSA that is in effect on the last day of a Plan Year cannot elect the HSA Contribution Benefit for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's Health FSA is \$0 as of the last day of that Plan Year. For this purpose, a Participant's Health FSA balance is determined on a cash basis – that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

**B.2 Benefit Contributions**

The annual Contribution for a Participant's Health FSA is equal to the annual Benefit amount elected by the Participant.

**B.3 Eligible Health Care Expenses**

Under the Health FSA, a Participant may receive reimbursement for Health Care Expenses incurred during the Period of Coverage for which an election is in force.

- **Incurred.** A Health Care Expense is incurred at the time the medical care or service giving rise to the expense is provided, and not when the Participant is formally billed for, is charged for, or pays for the medical care.
- **Health Care Expenses.** Health Care Expenses means expenses incurred by a Participant, or the Participant's Spouse or Dependent(s) covered under the Health FSA for medical care, as defined in Code §§213(d) and 106(f), other than expenses that are excluded by this Plan, but only to the extent that the Participant or other person incurring the expense is not reimbursed through any other accident or health plan.
- **Expenses That Are Not Reimbursable.** Insurance premiums are not reimbursable from the Health FSA. Other expenses that are not reimbursable are listed in Appendix A to the Plan Document.

**B.4 Maximum and Minimum Benefits**

- **Maximum Reimbursement Available; Uniform Coverage Rule.** The maximum dollar amount elected by the Participant for reimbursement of Health Care Expenses incurred during a Period of Coverage, reduced by prior reimbursements during the Period of Coverage, shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health FSA. Notwithstanding the foregoing, no reimbursements will be available for Health Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided below.
- **Payment shall be made to the Participant in cash as reimbursement for Health Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Section have been satisfied.**
- **Maximum Dollar Limit.** The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Health Care Expenses incurred in any Period of Coverage shall be the lesser of \$5,000.00 or the maximum allowed under federal regulations. Reimbursements due for Health Care Expenses incurred by the Participant's Spouse or Dependent(s) shall be charged against the Participant's Health FSA.
- **Changes.** For subsequent Plan Years, the maximum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Salary Reduction Agreement or another document.
- **No Proration.** If a Participant enters the Plan mid-year or wishes to increase his or her election mid-year as permitted under this Plan, then the Participant may elect coverage or increase coverage respectively, up to the maximum annual benefit amount stated above. The maximum annual benefit amount will not be prorated.
- **Effect on Maximum Benefits If Election Change Permitted.** Any change in an election affecting annual Contributions to the Health FSA will also change the maximum reimbursement benefits for the balance of the Period of Coverage commencing on the election change effective date. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding:
  - The aggregate Contribution for the period prior to such election change; to
  - The total Contribution for the remainder of such Period of Coverage to the Health FSA; reduced by
  - All reimbursements made during the entire Period of Coverage.
- **FMLA Leave.** Any change in an election for FMLA leave will change the maximum reimbursement benefits in accordance with FMLA or the regulations governing cafeteria plans.
- **Monthly Limits on Reimbursing OTC Drugs.** Only reasonable quantities of over-the-counter (OTC) drugs or medicines of the same kind may be reimbursed from a Participant's Health FSA in a single calendar month, even assuming that the drug otherwise meets the requirements of

this Section, including that it is for medical care under Code §§213(d) and 106(f). Stockpiling is not permitted.

#### **B.5 Establishment of Account**

The Plan Administrator will establish and maintain a Health FSA with respect to each Participant who has elected to participate in the Health FSA, but will not create a separate fund or otherwise segregate assets for this purpose. The account established hereto will merely be a record keeping account with the purpose of keeping track of Contributions and determining forfeitures.

- **Crediting of Accounts.** A Participant's Health FSA will be credited following each Salary Reduction actually made during each Period of Coverage with an amount equal to the Salary Reduction actually made.
- **Debiting of Accounts.** A Participant's Health FSA will be debited during each Period of Coverage for any reimbursement of Health Care Expenses incurred during the Period of Coverage.
- **Available Amount Not Based on Credited Amount.** The amount available for reimbursement of Health Care Expenses is the amount as calculated according to the "Maximum Reimbursement Available" paragraph of this Section above. It is not based on the amount credited to the Health FSA at a particular point in time.

#### **B.6 Use It or Lose It Rule; Forfeiture Of Account Balance**

- **Use It or Lose It Rule.** If any balance remains in the Participant's Health FSA for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Health Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. Claims must be submitted on or before April 15<sup>th</sup> of the year immediately following the close of the plan year in which the expenses were incurred.
- **Use of Forfeitures.** All forfeitures under this Plan shall be used as follows:
  - First, to offset any losses experienced by Employer during the Plan Year as a result of making reimbursements with respect to any Participant in excess of the Contributions paid by such Participant through Salary Reductions;
  - Second, to reduce the cost of administering the Health FSA during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and
  - To provide increased Benefits or compensation to all Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations.
- **Unclaimed Benefits.** Benefit payments that remain unclaimed by the close of the Plan Year following the Period of Coverage in which the Health Care Expense was incurred shall be forfeited and applied as described above.



#### **B.7 Reimbursement Procedure**

- **Timing.** Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Health Care Expenses, or the Plan Administrator will notify the Participant that a claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days from receipt of the written notice in which to complete an incomplete reimbursement claim.
- **Claims Substantiation.** A Participant who has elected to receive Health Care Reimbursement Benefits for a Period of Coverage may apply for reimbursement by submitting an application to the Plan Administrator by no later than the date set by the Plan Administrator each year, setting forth:
  - The person or persons on whose behalf Health Care Expenses have been incurred;
  - The nature and date of the expenses incurred;
  - The amount of the requested reimbursement;
  - A statement that such expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source; and
  - Other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Health Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Plan Administrator may request.

- **Claims Denied.** For appeal of claims that are denied, see the Appeals Procedure in the Plan Document.
- **Claims Ordering; No Reprocessing.** All claims for reimbursement will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized solely for the purpose of paying it from amounts attributable to a different Plan Year or Period of Coverage.

#### **B.8 Reimbursements After Termination; Limited COBRA Continuation**

The Participant will not be able to receive reimbursements for Health Care Expenses incurred after participation terminates. However, such Participant, or the Participant's estate, may claim reimbursement for any Health Care Expenses incurred during the Period of Coverage prior to termination, provided that the Participant, or the Participant's estate, files a claim by the date established in the Reimbursement Procedure paragraphs above following the close of the Plan Year in which the Health Care Expense was incurred.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and such Participant's Spouse and Dependent(s), whose coverage terminates under the Health FSA because of a COBRA qualifying event, shall be given the opportunity to continue the same coverage that the Participant had under the Health FSA the day before the qualifying event, subject to all conditions and limitations under COBRA. The Contributions for such continuation coverage will be equal to the cost of providing the same coverage to an active employee taking into account all costs incurred by the Employee and the Employer plus a 2% administration fee. Specifically, an individual will be eligible for COBRA continuation coverage only if the Participant's remaining available amount is greater than the Participant's remaining Contribution payments at the time of the qualifying event, taking into account all claims submitted before the date of the qualifying event. Such individual will be notified if the individual is eligible for COBRA continuation coverage.

If COBRA is elected, COBRA coverage will be subject to the most current COBRA rules. COBRA will be available only for the remainder of the Plan Year in which the qualifying event occurs. Such COBRA coverage for the Health FSA will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Coverage may terminate sooner if the Contributions for a Period of Coverage are not received by the due date established by the Plan Administrator for that Period of Coverage. Continuation coverage is only granted after the Plan Administrator has received the Contributions for that period of coverage.

Contributions for coverage for Health FSA Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation, as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from Contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year, where COBRA coverage arises either:

- Because the Employee ceases to be eligible because of a reduction of hours; or
- Because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage.

For all other individuals (for example, Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Health FSA Benefits shall be paid on an after-tax basis, unless permitted otherwise by the Plan Administrator, in its discretion and on a uniform and consistent basis, but may not be prepaid from Contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year.

#### **B.9 Qualified Reservist Distribution**

If a Participant meets all of the following conditions, the Participant may elect to receive a qualified reservist distribution from the Health FSA:

- The Participant's Contributions to the Health FSA for the Plan Year as of the date the qualified reservist distribution is requested exceeds the reimbursements the Participant has received from the Health FSA for the Plan Year as of that date.
- The Participant is ordered or called to active military duty for a period of at least 180 days or for an indefinite period by reason of being a member of the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air

National Guard of the United States, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.

- The Participant has provided the Plan Administrator with a copy of the order or call to active duty. An order or call to active duty of less than 180 days' duration must be supplemented by subsequent calls or orders to reach a total of 180 or more days.
- The Participant is ordered or called to active military duty on or after April 1, 2009, or the Participant's period of active duty begins before April 1, 2009 and continues on or after the date.
- During the period beginning on the date of the Participant's order or call to active duty and ending on the last day of the Plan Year during which the order or call occurred, the Participant submits a qualified reservist distribution election form to the Plan Administrator.

**Amount of Qualified Reservist Distribution.** If the above conditions are met, the Participant will receive a distribution from the Health FSA equal to his or her Contributions to the Health FSA for the Plan Year as of the date of the distribution request, minus any reimbursements received for the Plan Year as of that date.

**No Reimbursement for Expenses Incurred After Distribution Request.** Once a Participant requests a qualified reservist distribution, the Participant forfeits the right to receive reimbursements for Health Care Expenses incurred during the period that begins on the date of the distribution request and ends on the last day of the Plan Year. The Participant may, however, continue to submit claims for Health Care Expenses that were incurred before the date of the distribution request (even if the claims are submitted after the date of the qualified reservist distribution), so long as the total dollar amount of the claims does not exceed the amount of the Health FSA election for the Plan Year, minus the sum of the qualified reservist distribution and the prior Health FSA reimbursements for the Plan Year.

**Tax Treatment of a Qualified Reservist Distribution.** If the Participant receives a qualified reservist distribution, it will be included in his or her gross income and will be reported as wages on the Participant's Form W-2 for the year in which it is paid.

#### **B.10 Named Fiduciary**

The Plan Administrator is the Named Fiduciary for the Health FSA.

#### **B.11 Coordination of Benefits**

Health FSAs are intended to pay Benefits solely for Health Care Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the Health FSA shall not be considered a group health plan for coordination of benefits purposes, and the Health FSA shall not be taken into account when determining benefits payable under any other plan.

**Schedule C**  
**HSA Contribution Benefit**

Unless otherwise specified, terms capitalized in this Schedule C shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

**C.1 HSA Tax Advantages**

An Employee may elect to participate in the HSA Contribution Benefit by electing to pay the Contributions on a pre-tax Salary Reduction basis to the Employee's Health Savings Account (HSA) established and maintained outside the Plan by a trustee/custodian to which the Employer can forward Contributions to be deposited. This funding feature constitutes the HSA Contribution Benefit.

As described more fully herein, such election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed.

**C.2 Establishing an HSA**

For administrative convenience, the Employer may chose to make Contributions for Employees to HSAs established at a bank selected by the Employer or limit the number of HSA providers to whom it will forward Contributions-such a list is not an endorsement of any HSA provider. The selected bank will be an authorized HSA trustee. The forms necessary to establish an HSA at the selected bank will be provided to Participants. Participants are responsible for managing their own HSA, including choosing how HSA funds are invested and following the rules of the selected bank and the IRS. Once the Employer Contributions have been deposited in a Participant's HSA Contribution Benefit, the Participant has a non-forfeitable interest in the funds and is free to request a distribution of the funds or to move them to another HSA provider, to the extent permitted by law.

The HSA Contribution Benefit cannot be elected with the Health FSA. In addition, a Participant who has an election for the Health FSA that is in effect on the last day of a Plan Year cannot elect the HSA Contribution Benefit for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's Health FSA is \$0 as of the last day of the Plan Year. For this purpose, a Participant's Health FSA balance is determined on a cash basis -- that is, without regard to claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

**C.3 Certification of HSA Contribution Benefit Eligibility**

To be eligible for the HSA Contribution Benefit, an HSA Employee must certify to the Employer that he or she is eligible for an HSA contribution and does not have any non-HDHP coverage. A married Participant must also certify that his or her Spouse does not have any non-HDHP coverage. A Participant is required to notify the Employer immediately if there are any changes in the information contained in the certification. Failure to provide accurate and updated information could cause the HSA Contribution Benefit to be included in a Participant's gross income and may also be subject to excise tax.

#### **C.4 Maximum Contribution**

The annual Contribution for a Participant's HSA Contribution Benefit is equal to the annual Benefit amount elected by the Participant. In no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the Participant's HDHP coverage option for the calendar year in which the Contribution is made (for calendar year 2011, \$3,050 for self-coverage or \$6,150 for family coverage).

Participants age 55 or older may make an additional catch-up Contribution of \$1,000 per year.

In addition, the maximum annual Contribution shall be:

- Reduced by any matching or other Employer Contribution made on the Participant's behalf; and
- Prorated for the number of months in which the Participant is an HSA Eligible Individual.

#### **C.5 Recording Contributions for HSA**

The Plan Administrator will maintain records to keep track of Contributions an Employee makes via pre-tax Salary Reductions to his or her HSA, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

#### **C.6 Distributions from HSA Contribution Benefit**

Distribution from an HSA Contribution Benefit will be tax-free if the distribution is for expenses incurred for a Participant's health care as defined in IRC §213(d) or the health care of a Participant's legal Spouse or tax Dependents. Expenses must have been incurred after the establishment of the HSA Contribution Benefit to be tax-free. HSA Contribution Benefit distributions used to pay insurance premiums will not be tax-free unless they are used for COBRA coverage, qualified long-term care insurance, health insurance maintained while the individual is receiving unemployment compensation under federal or state law, or health insurance for an individual age 65 or over, other than a Medicare supplemental policy.

#### **C.7 Tax Treatment of HSA Contributions and Distributions**

The tax treatment of the HSA is governed by Code §223.

#### **C.8 Reporting Issues**

Each Participant will be responsible for reporting Contributions made to his or her HSA Contribution Benefit and for reporting distributions from the HSA. A Participant is also responsible for reporting whether or not HSA distributions were used for qualified health expenses or whether the distributions were taxable. A Participant should maintain records sufficient to demonstrate whether or not distributions were taxable.

**C.9 Voluntary Participation**

Participation in the HSA Contribution Benefit is entirely voluntary and may be terminated at any time by notifying the Employer. Although the Employer expects to continue this HSA Contribution Benefit indefinitely, it has the right to amend or terminate HSA Contribution Benefit at any time and for any reason. It is also possible that changes to the program will be necessary or advisable as a result of future changes in state or federal tax laws.

**C.10 HSA Not Intended to be an ERISA Plan**

The HSA Contribution Benefit under this Plan consist solely of the ability to make Contributions to the HSA on a pre-tax Salary Reduction basis. Terms and conditions of coverage and Benefits will be provided by and are set forth in the HSA, not this Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan.

The HSA is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible health expenses" as set forth in Code §223(d)(2). The Employer has no authority or control over the funds deposited in a HSA. Even though this Plan may allow pre-tax Salary Reduction contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

**Schedule D**  
**Dependent Care Assistance Program**

Unless otherwise specified, terms capitalized in this Schedule D shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

**D.1 Benefits**

An Employee can elect to participate in the DCAP to receive Benefits in the form of reimbursements for Dependent Care Expenses. If elected, the Benefit Option will be funded by the Participant on a pre-tax Salary Reduction basis. Unless an exception applies, as described in the Irrevocability of Elections and Exceptions section above, such election is irrevocable for the duration of the Period of Coverage to which it relates.

**D.2 Benefit Contributions**

The annual Contribution for a Participant's DCAP Benefits is equal to the annual Benefit amount elected by the Participant, subject to the Maximum Benefits paragraph below.

**D.3 Eligible Dependent Care Expenses**

Under the DCAP, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

- **Incurred.** A Dependent Care Expense is "incurred" at the time the Qualifying Dependent Care Service giving rise to the expense is provided, and not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services.
- **Dependent Care Expenses.** Dependent Care Expenses means expenses that are considered to be:
  - Employment-related expenses under Code §21(b)(2) relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse; and
  - Expenses for incidental household services, if incurred by the Employee to obtain Qualifying Dependent Care Services, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through any other Plan.

If only a portion of a Dependent Care Expense has been reimbursed elsewhere, the DCAP can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Schedule.

- **Qualifying Individual.** A Qualifying Individual is:
  - A tax dependent of the Participant as defined in Code §152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code §152(a)(1);

- A tax dependent of the Participant as defined in Code §152, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or
- A Participant's Spouse, as defined in Code §152, who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

In the case of divorced or separated parents, a child shall be treated as a Qualifying Individual of the custodial parent within the meaning of Code §152(e).

- **Qualifying Dependent Care Services.** Qualifying Dependent Care Services means services that both:
  - Relate to the care of a Qualifying Individual that enable the Participant and Spouse to remain gainfully employed after the date of participation in the DCAP and during the Period of Coverage; and
  - Are performed:
    - In the Participant's home; or
    - Outside the Participant's home for:
      - The care of a Participant's Dependent who is under age 13; or
      - The care of any other Qualifying Individual who regularly spends at least 8 hours per day in the Participant's household.

In addition, if the expenses are incurred for services provided by a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment or grant for such services, then the facility must comply with all applicable state and local laws and regulations.

- **Exclusions.** Dependent Care Expenses do not include amounts paid to or for:
  - An individual with respect to whom a personal exemption is allowable under Code §151(c) to a Participant or Participant's Spouse;
  - A Participant's Spouse;
  - A Participant's child, as defined in Code §152(f)(1), who is under 19 years of age at the end of the year in which the expenses were incurred; and
  - A Participant's Spouse's child, as defined in Code §152 (a)(i), who is under 19 years of age at the end of the year in which the expenses were incurred.



**D.4 Maximum Benefit**

- **Maximum Reimbursement Available and Statutory Limits.** The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's DCAP less amounts debited to the Participant's DCAP pursuant to the Maximum Contribution paragraph below.

Payment shall be made to the Participant as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Section have been satisfied.

No reimbursement otherwise due to a Participant hereunder shall be made to the extent that such reimbursement, when combined with the total amount of reimbursements made to date for the Plan Year, would exceed the year to date amount of Participant Contributions to the DCAP for the Period of Coverage or applicable statutory limit.

- **Maximum Dollar Limit.** The maximum dollar limit for a Participant is the smallest of the following amounts:
  - The Participant's Earned Income for the calendar year;
  - The Earned Income for the calendar year of the Participant's Spouse who:
    - Is not employed during a month in which the Participant incurs a Dependent Care Expense; and
    - Is either physically or mentally incapable of self-care or a full-time Student shall be deemed to have Earned Income in the amount of \$250 per month per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount of \$500 per month); or
  - \$5,000 for the calendar year or the maximum allowed under federal regulations, if:
    - The Participant is married and files a joint federal income tax return; or
    - The Participant is married, files a separate federal income tax return, and meets the following conditions:
      - The Participant maintains as his or her home a household that constitutes, for more than half of the taxable year, the principal abode of a Qualifying Individual;
      - The Participant furnishes over half of the cost of maintaining such household during the taxable year; and
      - During the last six months of the taxable year, the Participant's Spouse is not a member of such household; or

- The Participant is single or is the head of the household for federal income tax purposes.
- \$2,500 for the calendar year, or the maximum allowed under federal regulation, if the Participant is married and resides with the Spouse, but files a separate federal income tax return.
- **Changes.** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Salary Reduction Agreement or another document.
- **No Proration.** If a Participant enters the Plan mid-year or wishes to increase his or her election mid-year as permitted under this Plan, then the Participant may elect coverage or increase coverage respectively, up to the maximum annual benefit amount stated above. The maximum annual benefit amount will not be prorated.
- **Effect on Maximum Benefits If Election Change Permitted.** Any change in an election affecting annual Contributions to the DCAP component will also change the maximum reimbursement Benefits for the balance of the Period of Coverage commencing with the election change effective date. Such maximum reimbursement Benefits for the balance of the Period of Coverage shall be calculated by adding:
  - The aggregate Contribution for the period prior to such election change; to
  - The total Contribution for the remainder of such Period of Coverage to the DCAP; reduced by
  - All reimbursements made during the entire Period of Coverage.

#### **D.5 Establishment of Account**

The Plan Administrator will establish and maintain a DCAP with respect to each Participant who has elected to participate in the DCAP, but will not create a separate fund or otherwise segregate assets for this purpose. The account so established will merely be a record keeping account with the purpose of keeping track of Contributions and determining forfeitures.

- **Crediting of Accounts.** A Participant's DCAP will be credited following each Salary Reduction actually made during each Period of Coverage with an amount equal to the Salary Reduction actually made.
- **Debiting of Accounts.** A Participant's DCAP will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.
- **Available Amount is Based on Credited Amount.** The amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCAP, less any prior reimbursements. A Participant's DCAP may not have a negative balance during a Period of Coverage.

**D.6 Unused Year End Balance**

- **Use It or Lose It Rule.** If any balance remains in the Participant's DCAP after all reimbursements have been made for the Period of Coverage, it shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during the subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. Claims must be submitted on or before April 15<sup>th</sup> of the year immediately following the close of the plan year in which the expenses were incurred.
- **Use of Forfeiture.** All forfeitures shall be used by the Plan in the following ways:
  - To offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements with respect to all Participants in excess of the Contributions paid by such Participant through Salary Reduction;
  - To reduce the cost of administering the DCAP during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and
  - To provide increased Benefits or Compensation to Participants in subsequent years in any weighted or uniform fashion the Plan Administrator deems appropriate, and consistent with applicable regulations.
- **Unclaimed Benefits.** Any DCAP Benefit payments that are unclaimed by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be applied as described above.

**D.7 Reimbursement Procedure**

- **Timing.** Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses or the Plan Administrator will notify the Participant that a claim has been denied. This time period may be extended an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days from receipt of the written notice in which to complete an incomplete reimbursement claim.
- **Claims Substantiation.** A Participant who has elected to receive DCAP Benefits for a Period of Coverage may apply for reimbursement by completing, signing, and returning an application to the Plan Administrator by no later than the date set by the Plan Administrator each year, setting forth:
  - The person or persons on whose behalf Dependent Care Expenses have been incurred;
  - The nature and date of the expenses incurred;
  - The amount of the requested reimbursement;
  - The name of the person, organization or entity to whom the expense was or is to be paid;

- A statement that such expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source;
- The Participant's certification that he or she has no reason to believe that the reimbursement refunded, added to other reimbursements to date will exceed the limit herein; and
- Other such details about the expenses that may be requested by the Plan Administrator.

The Participant shall include bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Plan Administrator may request.

- **Claims Denied.** For appeals of claims that are denied, see the Appeals Procedure in the Plan Document.

#### **D.8 Reimbursements After Termination**

If a Participant's employment terminates, the Participant may submit for reimbursement Dependent Care Expenses incurred after the date of termination up to the amount of the Participant's remaining DCAP Benefits.

#### **D.9 DCAP Participant vs. Claiming the Dependent Care Tax Credit**

Employees often have the choice between participating in their employer's DCAP on a Salary Reduction basis or taking a Dependent Care Tax Credit under Code §21. Employees cannot take advantage of both tax benefit options. Employees with questions regarding which option is best should consult with an accountant.

*AUTHORITY: section 33.103, RSMo Supp. [2007] 2010. Original rule filed March 15, 1988, effective June 1, 1988. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Dec. 21, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership  
EMERGENCY AMENDMENT**

**22 CSR 10-2.010 Definitions.** The Missouri Consolidated Health Care Plan is deleting sections (3), (19), (26), (33), (37), (44), (48), (51), (55), (56), (63), (65), (70), (72), (79), (93)–(95), (97), (100), (115), (125), and (129); amending sections (5), (9), (12), (17), (21), (25), (30), (34), (35), (37), (38), (42), (45), (47)–(49), (51), (52), (55), (68), (75)–(77), (79), (82), (88), (89), (91), (92), (94), (95), (97), (99), (101), (103)–(105), (108), (110), (112)–(114), (116), (117), (119), (123), and (128); adding sections (2), (7), (8), (14), (15), (29), (31), (33), (40), (41), (44), (53), (56), (67), (69), (70), (73), (96), (125), (130), and (132)–(134); and renumbering as necessary.

*PURPOSE: This amendment changes policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan relative to state members.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

*PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.*

**(2) Activities of daily living.** Bathing, dressing, toileting, and associated personal hygiene; transferring (being moved in and out of a bed, chair, wheelchair, tub, or shower); mobility, eating (get-

ting nourishment into the body by any means other than intravenous), and continence (voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

*[(2)](3) Administrative appeal.* A written request submitted by or on behalf of a member involving Missouri Consolidated Health Care Plan (MCHCP) administrative issues such as eligibility, effective dates of coverage, plan changes, etc.

*[(3) Administrative guidelines. Instructive interpretation of the plan document developed for administration of the plan. The administrative guidelines may be changed upon approval of the executive director or his/her designee. Benefits provided shall be those in effect at the time services are rendered.]*

**(5) Allowable expense.** Charges for services rendered or supplies furnished by a health plan that would qualify as covered expenses and for which the program pays in whole or in part, subject to any deductible[, and coinsurance[, or table of allowance included in the program] amounts.

**(7) Applied behavior analysis.** The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior.

**(8) Assignment.** When a doctor agrees to accept Medicare's fee as full payment.

*[(7)](9) Benefit period.* The three hundred sixty-five (365) days immediately [following the first date of like services] after the first date of services to treat a given condition.

*[(8)](10) Benefits.* Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator.

*[(9)](11) Birthday rule.* If both parents have medical coverage, the primary plan for dependent children is the plan of the parent whose birthday occurs first in the calendar year. If birthdays occur on the same day, the parent's coverage that has been in effect longest is primary.

*[(10)](12) Board.* The board of trustees of the Missouri Consolidated Health Care Plan (MCHCP).

*[(11)](13) Calendar year.* The period of time from January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All annual deductibles and benefit maximums accumulate during the calendar year.

**(14) Cancellation of Coverage.** The voluntary cancellation of medical, dental, or vision coverage per a subscriber's request.

**(15) Case management.** A coordinated set of activities conducted for individual patient management of serious or complicated health conditions.

*[(12)](16) Chiropractic services.* The examination, diagnosis, adjustment, manipulation, and treatment of malpositioned articulations and structures of the body, directed toward restoring and maintaining the normal neuromuscular and musculoskeletal function and health.

*[(13)](17) Claims administrator.* An organization or group responsible for the processing of claims and associated services for [the plan's self-insured benefit programs, including but not limited

to the preferred provider organization (PPO) (also known as the copay plan) and health maintenance organization (HMO) type plans] a health plan.

[(14)](18) Coinsurance. The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.

[(15)](19) Comprehensive major medical. A plan that provides for cost sharing to be applied to all covered expenses, such as deductible or coinsurance.

[(16)](20) Congenital defect. Existing or dating from birth. Acquired through development while in the uterus.

[(17)](21) Convenient care clinics (CCCs). Health care clinics located in retail stores, supermarkets, and pharmacies that treat routine family illnesses and provide preventive health care services. They are sometimes referred to as “retail-based clinics” or “walk-in medical clinics.” *[CCCs are usually staffed by nurse practitioners or physician assistants. Some CCCs, however, are staffed by physicians.]*

[(18)](22) Coordination of benefits. Communication, adjustment, and reconciliation procedures between multiple benefit plans covering the same member for purposes of covering services and expenses relating to plan benefits.

[(19) Copay plan. A set of benefits similar to a health maintenance organization option.]

[(20)](23) Copayment. A set dollar amount that the covered individual must pay for specific services.

[(21)](24) Cosmetic surgery. A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than restore the anatomy and/or functions of the body which are lost or impaired due to illness or injury.

[(22)](25) Covered benefits and charges. *[A schedule of covered services and charges payable under the plan. The benefits covered under each type of plan are outlined in the applicable rule in this chapter.]* Covered benefits are a schedule of health care services payable under the plan. Covered charges are the cost for medical services eligible for consideration under the plan.

[(23)](26) Custodial care. Services and supplies furnished primarily to assist an individual to meet the activities of daily living. *Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services* that can be provided by persons without the training of a health care provider or that do not entail and require the continuing attention of trained medical or paramedical personnel.

[(24)](27) Date of service. Date medical services are received or performed.

[(25)](28) Deductible. The amount of expense the member must pay before the plan begins to pay for covered services and supplies. This amount is not reimbursable by the plan.

[(26) Dependent-only participation. Participation of certain survivors of subscribers. Dependent participation may be further defined to include the deceased subscriber's:

- (A) Spouse only;
- (B) Child(ren) only; or
- (C) Spouse and child(ren).]

(29) Dependent child. Any child under the age of twenty-six (26)

that is a natural child, legally adopted or placed for adoption child, or a child with one (1) of the following legal relationships with the member, so long as such legal relationship remains in effect:

- (A) Stepchild;
- (B) Foster child for whom the employee is responsible for health care;
- (C) Grandchild for whom the employee has legal guardianship or legal custody and is responsible for providing health care; and
- (D) Other child for whom the employee is the court-ordered legal guardian responsible for providing health care.

1. Except for a disabled child as described in 22 CSR 10-2.010(89), a dependent child is eligible from his/her eligibility date to the end of the month he/she attains age twenty-six (26) (see paragraph 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child beyond age twenty-six (26)).

[(27)](30) Dependents. The lawful spouse of the employee, the employee's *[unemancipated]* child(ren), and certain survivors of employees, as provided in the plan document and these rules, for whom *[application]* enrollment has been made and has been accepted for participation in the plan.

(31) Diagnostic. Describes a procedure to determine whether a person has a particular illness.

[(28)](32) Diagnostic charges. The Usual, Customary, and Reasonable (UCR) charges or the network discounted rate (NDR) for x-ray or laboratory examinations made or ordered by a physician in order to detect a medical condition.

(33) Disease management. A program offered to non-Medicare members to help manage certain chronic diseases.

[(29)](34) Disposable supplies. *[Medical s/Supplies* that do not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.

[(30)](35) Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:

- (A) Doctor of medicine;
- (B) Doctor of osteopathy;
- (C) Podiatrist;
- (D) Optometrist;
- (E) Chiropractor;
- (F) Psychiatrist;
- [(F)](G) Psychologist;
- [(G)](H) Doctor of dental medicine, including dental surgery;

or/

(I) Doctor of dentistry; or

[(H)](J) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

[(31)](36) Durable medical equipment (DME). Equipment able to withstand repeated use for the therapeutic treatment of an active illness or injury. Such equipment is not covered under the plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.

[(32)](37) Eligibility date. *[Refer to]* As described in 22 CSR 10-2.020. *[for effective date provisions.*

(A) Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of employment or reemployment.

(B) Employees transferred from a state department with coverage under another medical care plan into a state

*department covered by this plan and their eligible dependents who were covered by the other medical care plan are eligible for participation immediately.*

*(C) Employees who terminate all employment with the state (not simply move from one (1) agency to another) and are rehired as a new state employee before termination of participation, and their eligible dependents who were covered by the plan, will be eligible for participation immediately.*

*(D) Employees who terminate all employment with the state (not simply move from one (1) agency to another) and are rehired as a new state employee in the subsequent month, and their eligible dependents who were covered by the plan, will be eligible for participation retroactive to the date following termination of participation or at the employee's choice, on the first day of the month following the employee's date of rehire.]*

*[(33) Emancipated child(ren). A child(ren) who is:*

*(A) Employed on a full-time basis;*

*(B) Eligible for group health benefits in his/her own behalf;*

*(C) Maintaining a residence separate from his/her parents or guardian, except for full-time students in an accredited school or institution of higher learning; or*

*(D) Married.]*

*[(34)](38) Emergency medical condition. [Any medical condition leading a prudent layperson to seek immediate medical attention. This normally means the sudden onset of a health condition that manifests itself by acute symptoms and severity (including severe pain). Examples of medical emergencies include, but are not limited to:] A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—*

*(A) Conditions placing a person's health in significant jeopardy;*

*(B) Serious impairment to a bodily function;*

*(C) Serious dysfunction of any bodily organ or part;*

*(D) Inadequately controlled pain; or*

*(E) Situations when the health of a pregnant woman or her unborn child are threatened.*

*[(35)](39) Emergency room. The section of a hospital equipped to furnish emergency care to prevent the death or serious impairment of the covered person.*

**(40) Emergency Services. With respect to an emergency medical condition—**

**(A) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department to evaluate such emergency medical condition; and**

**(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the patient. The term "to stabilize" means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility.**

**(41) Employee. A person employed by the state and present and future retirees from state employment who meet the eligibility requirements as prescribed by law.**

*[(36)](42) Employee and dependent participation. Participation of an employee and the employee's eligible dependents. Any individual eli-*

*gible for participation as an employee is [not] eligible as a dependent up to the age of twenty-six (26), except as noted in 22 CSR 10-2.020(1)(A)3. [Dependent participation may be further defined to include the participating employee's:*

*(A) Spouse only;*

*(B) Child(ren) only; or*

*(C) Spouse and child(ren).]*

*[(37) Employees. Employees of the state and present and future retirees from state employment who meet the eligibility requirements as prescribed by state law.]*

*[(38)](43) Employer. The state department or agency that employs the eligible employee as defined above.*

**(44) Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:**

**(A) Ambulatory patient services—office visits, urgent care, outpatient diagnostic procedures, outpatient surgery, and outpatient hospice;**

**(B) Emergency services—ambulance services and emergency room services;**

**(C) Hospitalization—inpatient hospital benefits, inpatient surgery, transplants, and inpatient hospice;**

**(D) Maternity and newborn care—maternity coverage and newborn screenings;**

**(E) Mental health and substance abuse disorder services, including behavioral health treatment—inpatient and outpatient and mental health/chemical dependency office visits;**

**(F) Prescription drugs;**

**(G) Rehabilitative and habilitative services and devices—durable medical equipment; cardiac and pulmonary rehabilitation; outpatient physical, speech, and occupational therapy; and home health care/palliative services;**

**(H) Laboratory services—lab and x-ray;**

**(I) Preventive and wellness services and chronic disease management; and**

**(J) Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, immunizations, preventive services, and newborn screenings.**

*[(39)](45) Executive director. The chief executive officer of the Missouri Consolidated Health Care Plan (MCHCP) who shall have charge of the offices, records, and employees of the plan, subject to the direction of the board of trustees.*

*[(40)](46) Experimental/Investigational/Unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below is considered experimental/investigational/unproven and is not eligible for coverage under the plan. Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community. Experimental/investigational/unproven is defined as a treatment, procedure, device, or drug that the plan administrator determines, in the exercise of its discretion:/—*

*(A) Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law;*

*(B) Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or*

*(C) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its*

maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficiency as compared with the standard means of treatment or diagnosis.

**[(41)](47)** First eligible. The first thirty-one (31)-day period after a member's employment date in which the member and his/her dependents may enroll in an MCHCP plan. As a member acquires new dependents, his/her first *[eligible]* **eligibility** period is the first thirty-one (31) days from the date *[the dependent meets the eligibility requirements for coverage under the plan]* **of the life event**.

**[(42)](48)** Formulary. A list of drugs covered by the pharmacy *[program claims administrator]* **benefit manager** and as allowed by the plan administrator.

**[(43)](49)** Generic drug. *[The chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.]* **There are two (2) types of generic drugs, a therapeutically equivalent generic and a chemically equivalent generic, as defined below.**

**(A)** Therapeutically equivalent generic drugs are drugs with active ingredients that are similar at the clinical level.

**(B)** Chemically equivalent generic drugs are drugs with active ingredients that are identical at the molecular level. The brand-name drug lost its patent and the generic is available for the exact drug.

**[(44)]** *Grievance. A written complaint submitted by or on behalf of a member regarding either:*

*(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or*

*(B) Claims payment, handling, or reimbursement for health care services.]*

**[(45)](50)** Group health plan. A plan maintained by an employer or an employee organization to provide medical care or other health services, directly or indirectly, to employees, former employees, and their families, including but not limited to Medicare and Medicaid plans.

**[(46)](51)** Handbook. The summary plan document prepared for members explaining the terms, conditions, and all material aspects of the plan and benefits offered under the plan, a copy of which is incorporated by reference into this rule. The full text of material incorporated by reference *[will be made]* is available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, 2010 State Member Handbook *[(January 1, 2010)]* **January 10, 2011** or online at [www.mchcp.org](http://www.mchcp.org). It does not include any later amendments or additions.

**[(47)](52)** Health assessment **(HA)**. A questionnaire about a member's health and lifestyle habits *[which qualifies the member]* **required** for participation in the *[Lifestyle Ladder program to earn the incentive premium]* **wellness program**.

**(53) Health care benefit.** Coverage under the plan to include medical, dental, vision, and pharmacy.

**[(48)]** *Health maintenance organization (HMO). A plan that provides for a wide range of comprehensive health care services for a specified group at a fixed periodic prepayment.]*

**[(49)](54)** Health savings account (HSA). A tax-advantaged savings account that may be used to pay current or future qualified medical

expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA. HSA funds can be used to help pay the deductible, coinsurance, and any qualified medical expenses not covered by the health plan.

**[(50)](55)** High Deductible Health Plan (HDHP). A health plan with higher deductibles than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

**[(51)]** *Home health agency. An agency certified by Medicare and the Missouri Department of Health and Senior Services, or any other state's licensing or certifying body, to provide health care services to persons in their homes.]*

**(56) Home health care.** Skilled nursing services and other therapeutic services to persons in their homes provided by an agency certified by Medicare and licensed pursuant to state or local law.

**[(52)](57)** Hospice. A public agency, private organization, or a subdivision of either that primarily engages in providing care to terminally ill individuals, meets the conditions of participation for hospices, holds a valid Medicare provider agreement, and is licensed pursuant to state law.

**[(53)](58)** Hospice facility. A public or private organization, certified by Medicare and any other state's licensing or certifying body, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one (1) physician, one (1) registered nurse, one (1) social worker, one (1) volunteer, and a volunteer program. A hospice facility is not a facility or part thereof which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.

**[(54)](59)** Hospital.

**(A)** An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic, and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24)-hour-a-day nursing service by a registered nurse (RN) on duty or call.

**(B)** An institution not meeting all the requirements of **[(54)](A)]** **subsection (59)(A)** above, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

**(C)** An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).

**(D)** A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.

**(E)** A residential alcoholism, chemical dependency, or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction.

**(F)** In no event shall the term hospital include a skilled nursing facility or any institution or part thereof which is used primarily as a skilled nursing facility, nursing home, rest home, or facility for the aged.

**[(55)]** *Hospital copayment. Set dollar amount a subscriber must pay for each hospital admission.]*

**[(56)]** *Hospital room charges. The hospital's most common charge for semi-private accommodations, or the most common charge for a private room if that is the only type of room available or if a private room has been recommended*



*by a physician and approved by the claims administrator or the plan administrator.]*

[(57)](60) **Illness.** Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered as any other illness.

[(58)](61) **Incident.** A definite and separate occurrence of a condition.

[(59)](62) **Infertility.** Any medical condition causing the inability or diminished ability to reproduce.

[(60)](63) **Infertility services.** Services including confinement, treatment, or other services related to the restoration of fertility or the promotion of conception.

[(61)](64) **Injury.** A condition that results independently of an illness and all other causes and is a result of an external force or accident.

[(62)](65) **Inpatient.** Confined to a registered bed. Patient in hospital, skilled nursing facility, hospice facility, or free-standing chemical dependency treatment center.

[(63)] *Legend. Any drug that requires a prescription from either a physician or a practitioner, under either federal or applicable state law, in order to be dispensed.]*

[(64)](66) **Life events.** Events occurring in an individual's life to include: marriage, birth, adoption, or placement of children.

**(67) Lifestyle Ladder. MCHCP's wellness program.**

[(65)] *Lifetime. The period of time a member or the member's eligible dependents participate in the plan.]*

[(66)](68) **Lifetime maximum.** The [maximum] amount payable by a medical plan during a covered member's life **for specific non-essential benefits.**

**(69) MCHCPid.** An individual MCHCP member identifier used for member verification and validation.

**(70) myMCHCP.** A secure MCHCP member website that includes coverage selection, level of coverage, an option to change a mailing address, an option to add or change an email address, an option to request an MCHCPid card, and access to other pertinent websites.

[(67)](71) **Medical benefits coverage.** Services that are received from providers recognized by the plan and are covered benefits under the plan.

[(68)](72) **Medically necessary.** Treatments, procedures, services, or supplies that the plan administrator determines, in the exercise of its discretion:—

(A) Are expected to be of clear clinical benefit to the patient; and

(B) Are appropriate for the care and treatment of the injury or illness in question; and

(C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.

**(73) Medicare approved amount.** The fee Medicare sets as reasonable for a covered medical service. This is the amount a provider is paid by the member and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or provider.

[(69)](74) **Member.** Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

[(70)] *Morbid obesity. Body Mass Index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions approved by the plan administrator based on clinical review.]*

[(71)](75) **Network provider.** A physician, hospital, pharmacy, [etc.] or **other health provider** that is contracted with the plan or its designee.

[(72)] *Non-embedded deductible. The family deductible that must be met before claim payments begin, applicable when two (2) or more family members are covered in the HDHP.]*

[(73)](76) **Non-formulary.** A drug not contained on the pharmacy [program's formulary] **benefit manager's list [but may be covered under the terms and conditions of the plan] of covered drugs.**

[(74)](77) **Non-network provider or non-participating provider.** A[ny] physician, hospital, pharmacy, [etc.] or **other health provider** that does not have a contract with the plan or its designee.

[(75)](78) **Nurse.** A registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule.

[(76)](79) **Nursing home.** An institution operated, pursuant to law, primarily for custodial care or for patients [convalescing] **recovering** from illness or injury, under the supervision of a physician or registered nurse and having twenty-four (24)-hour nursing care. Also, an institution meeting the preceding criteria which is established for the treatment of sick and injured persons through spiritual means and is operated under the authority of organizations [which] **that** are recognized under Medicare.

[(77)](80) **Open enrollment period.** A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year.

[(78)](81) **Out-of-area.** Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria.

[(79)] *Out-of-network. Providers that do not participate in the member's health or pharmacy plan.]*

[(80)](82) **Out-of-pocket maximum.** [The maximum amount the member must pay before the plan begins paying one hundred percent (100%) of covered charges for the remainder of the calendar year.] **The annual limit on the amount a member must pay for covered services. Above this limit, the medical plan pays**

**one hundred percent (100%) for covered services for the rest of the plan year.**

**[(81)](83)** Outpatient. Treatment either outside a hospital setting or at a hospital when room and board charges are not incurred.

**[(82)](84)** Outpatient observation stay. Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services are less than twenty-four (24) hours. Members may receive observation services in the emergency room, an observation unit, the intensive care unit, or a regular floor.

**[(83)](85)** Palliative services. Care provided by a team approach that improves the quality of life for patients and their families facing problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and *[impeccable]* assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

**[(84)](86)** Partial hospitalization. A distinct and organized intensive ambulatory treatment service, less than twenty-four (24)-hour daily care specifically designed for the diagnosis and active treatment of a mental/nervous disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.

(A) Partial hospitalization programs must provide diagnostic services; services of social workers; *[psychiatric]* nurses and staff trained to work with psychiatric patients; individual, group, and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions *[for therapeutic purposes]*.

(B) The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a physician.

**[(85)](87)** Participant. Any employee or dependent accepted for membership in the plan.

**[(86)](88)** Pharmacy benefit manager (PBM). *[Acts as a link between the parties involved in the delivery of prescription drugs to health plan members.]* The PBM designs, implements, and manages the overall drug benefit of the plan and processes claims payments.

**[(87)](89)** Physically or mentally disabled. *[The inability of a person]* **A person's inability** to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition.

**[(88)](90)** Physician/Doctor. A licensed practitioner of the healing arts, acting within the scope of his/her practice, as licensed under section 334.021, RSMo.

**[(89)](91)** Plan. The program of health care benefits established by the **board of** trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

**[(90)](92)** Plan administrator. The **board of** trustees of the Missouri Consolidated Health Care Plan. *As such, the board*, **which** is the sole fiduciary of the plan. *]. The board* has all discretionary authority to interpret its provisions and to control the operation and administration of the plan. *and whose decisions are final and binding on all parties.*

**[(91)](93)** Plan document. The statement of the terms and conditions of the plan as promulgated by the plan administrator in this chapter.

**[(92)](94)** Plan year. *[Same as]* The calendar year **beginning January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All deductibles and benefit maximums accumulate during the calendar year.**

**[(93)]** *Pre-admission testing. X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission.]*

**[(94)]** *Pre-certification. Also known as pre-admission certification, pre-admission review, and pre-certification. The process of obtaining certification or authorization from the plan for routine hospital admissions and surgical or diagnostic procedures (inpatient or outpatient).]*

**[(95)]** *Pre-existing condition. A condition for which a member has incurred medical expenses or received treatment prior to the effective date of coverage.]*

**[(96)](95)** Preferred provider organization (PPO). An arrangement with providers whereby discounted rates are given to **plan members** *[of the plan who, in turn, are offered a financial incentive to use these providers]. Benefits are paid at a higher level when network providers are used.*

**[(97)]** *Prevailing fee. The fee charged by the majority of dentists.]*

**(96)** Preventive service. A procedure intended for avoidance or early detection of an illness.

**[(98)](97)** Primary care physician (PCP). A physician (usually an internist, family/general practitioner, or pediatrician) who has contracted with *[and been approved by]* a medical plan.

**[(99)](98)** Prior authorization. A cost control procedure that requires the service or medication to be approved in advance by the doctor and/or the plan. Without prior authorization, the plan may not pay for the test, drug, or service. Also known as pre-authorization or pre-notification.

**[(100)]** *Prior plan. The terms and conditions of a plan in effect for the period preceding coverage in the plan.]*

**[(101)](99)** Private duty nursing. *[Private duty nursing services, n/Nursing care on a full-time basis in the member's home[,], or home health aides.*

**[(102)](100)** Proof of eligibility. Documentation required by the plan to determine a dependent's qualification for health insurance coverage.

**[(103)](101)** Proof of **prior group** insurance. Evidence in written form from an insurance company that provides verification of coverage for a given period of time.

**[(104)](102)** Proof of prior group coverage. If a member or his/her dependents enroll in the plan due to loss of coverage, the member must provide proof of prior group coverage. This includes a letter from the previous insurance carrier or former employer which states all the following:

- (A) Date coverage was or will be terminated;
- (B) Reason for coverage termination; and
- (C) List of dependents covered.

**[(105)](103)** Prostheses. An artificial extension that replaces a missing part of the body. *Prostheses are typically used to replace parts lost by injury (traumatic) or missing from birth (congenital)] or [to] supplements defective parts.*

**[(106)](104) Protected health information (PHI).** Any information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. This information also relates to the past, present, or future physical or mental health or condition of the individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual.

**[(107)](105) Provider.** *[Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.]* A physician, hospital, medical agency, specialist, or other duly-licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-2.010(35). Other providers include but are not limited to:

- (A) Audiologist (AUD or PhD);
- (B) Certified Addiction Counselor for Substance Abuse (CAC);
- (C) Certified Nurse Midwife (CNM)—when acting within the scope of their license in the state in which they practice and performing a service which would be payable under this plan when performed by a physician;
- (D) Certified Social Worker or Masters in Social Work (MSW);
- (E) Licensed Clinical Social Worker;
- (F) Licensed Professional Counselor (LPC);
- (G) Licensed Psychologist (LP);
- (H) Nurse Practitioner (NP);
- (I) Physicians Assistant (PA);
- (J) Qualified Occupational Therapist;
- (K) Qualified Physical Therapist;
- (L) Qualified Speech Therapist;
- (M) Registered Nurse Anesthetist (CRNA);
- (N) Registered Nurse Practitioner (ARNP); or
- (O) Therapist with a PhD or Master's Degree in Psychiatry or related field.

**[(108)](106) Provider directory.** A listing of network providers within a health plan.

**[(109)](107) Prudent layperson.** An individual possessing an average knowledge of health and medicine.

**[(110)](108) Qualified Medical Child Support Order (QMCSO).** A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or *[an enrollee]* member if the plan normally provides coverage for dependent children.

**[(111)](109) Reconstructive surgery.** A procedure performed to restore the anatomy and/or functions of the body that are lost or impaired due to an injury or illness.

**[(112)](110) Refractions.** A record of the patient's preference for the focusing of the eyes that *[can]* may then be used to purchase eyeglasses or contact lenses. It is the *[portion of the eye]* part of the exam that determines what prescription lens *[provides]* gives the patient *[with]* the best possible vision.

**[(113)](111) Rehabilitation facility.** A legally operating institution, or distinct part of an institution, that has a transfer agreement with one (1) or more hospitals and is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute

hospital, and rehabilitative inpatient care and is duly licensed by the appropriate government agency to provide such services.

(A) It does not include institutions that provide only minimal care, custodial care, ambulatory or part-time care services, or an institution that primarily provides treatment of mental/nervous disorders, substance abuse, or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission for the Accreditation of Rehabilitation Facilities.

**[(114)](112) Retiree.** A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-2.020[(5)(B)](7)(B) and is currently receiving a monthly retirement benefit from *[one (1) of the]* a retirement system/s listed in such rule.

**[(115) Second opinion program.** A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service.]

**[(116)](113) Skilled nursing care.** *[Care which]* Services that must be performed by, or under the supervision of, licensed personnel and meets criteria as established by the claims administrator.

**[(117)](114) Skilled nursing facility (SNF).** *[An institution which meets fully each of the following requirements:*

(A) *It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board, and twenty-four (24)-hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;*

(B) *It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and*

(C) *A skilled nursing facility shall be deemed to include institutions meeting the criteria in this rule which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97).]* A public or private facility licensed and operated according to the law that provides—

(A) Permanent and full-time facilities for ten (10) or more resident patients;

(B) A registered nurse or physician on full-time duty in charge of patient care;

(C) At least one (1) registered nurse or licensed practical nurse on duty at all times;

(D) A daily medical record for each patient;

(E) Transfer arrangements with a hospital; and

(F) A utilization review plan.

The facility must be primarily engaged in providing continuous skilled nursing care for persons during the recovery stage of their illness or injury, and is not, other than by coincidence, a rest home for custodial care or for the aged.

**[(118)](115) Sound natural teeth.** Teeth and/or tissue that is viable, functional, and free of disease. A sound natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

*[(119)](116)* Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

*[(120)](117)* Specialty medications. High cost drugs that are primarily self-injectible; *[but]* sometimes oral medications.

*[(121)](118)* State. Missouri.

*[(122)](119)* Step therapy. Designed to encourage use of therapeutically-equivalent, lower-cost alternatives before *[stepping up to]* using more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

*[(123)](120)* Subrogation. The substitution of one (1) "party" for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the participant and recover the money directly from the other insurer.

*[(124)](121)* Subscriber. The employee or member who elects coverage under the plan.

*[(125) Subscriber only participation. Participation of a subscriber without participation of the subscriber's dependents, whether or not the subscriber has dependents.]*

*[(126)](122)* Surgery. Any operative or invasive diagnostic procedure performed in the treatment of an injury or illness by an instrument or cutting procedure through any natural body opening or incision.

*[(127)](123)* Surgery center (ambulatory). A hospital-based, **hospital**-sponsored, or independently-owned facility that performs surgery.

*[(128)](124)* Survivor. A member who meets the requirements of subsection 22 CSR 10-2.020[(5)(A)](7)(A).

**(125) Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.**

*[(129) Unemancipated child(ren). A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-five (25) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:*

*(A) Stepchild(ren);*

*(B) Foster child(ren) for whom the employee is responsible for health care;*

*(C) Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care; and*

*(D) Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator.*

*1. Except for a disabled child(ren) as described in section (87) of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-five (25) (see paragraph 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child(ren) beyond age twenty-five (25)); and*

*(E) Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for*

*providing coverage is also covered as a dependent under the plan.]*

*[(130)](126)* Urgent care. Medically necessary services in order to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician office but not severe enough to require treatment in a hospital emergency department.

*[(131)](127)* Urgent care centers. Medical facilities that provide extended or twenty-four (24)-hour service to treat minor conditions at a lower cost than emergency room treatment.

*[(132)](128)* Usual, Customary, and Reasonable charge.

(A) Usual. The fee a *[physician]* **provider** most frequently charges the majority of his/her patients for the same or similar services.

(B) Customary. The range of fees charged in a geographic area by *[physicians]* **providers** of comparable skills and qualifications for the same performance of similar service.

(C) Reasonable. The flexibility to take into account any unusual clinical circumstances involved in performing a particular service.

(D) A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the *[doctors]* **providers** for ninety percent (90%) of the procedures reported.

*[(133)](129)* Utilization review. Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities on a prospective, concurrent, or retrospective basis.

**(130) Vendor. The current applicable third-party administrator of MCHCP benefits.**

*[(134)](131)* Vested subscriber. A member who meets the requirements of subsection 22 CSR 10-2.020[(5)(B)](7)(B).

**(132) Wellness participation year. Year in which members may participate in the wellness program per plan year: October 1–September 25.**

**(133) Wellness program. A voluntary program focusing on awareness, health education, and behavior change.**

**(134) Wellness premium. The monthly medical premium applied to members who successfully complete all requirements of the Lifestyle Ladder program.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

## **Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership**

### **EMERGENCY AMENDMENT**

**22 CSR 10-2.020 [Subscriber Agreement and] General Membership Provisions.** The Missouri Consolidated Health Care

Plan is amending the rule title and purpose; amending sections (1)–(3) and (5)–(10); adding new sections (5), (6), and (11)–(13); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the General Membership Provisions of the Missouri Consolidated Health Care Plan.*

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the [Subscriber Agreement and] General Membership Provisions of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) *[The participant's initial application, any subsequently accepted modifications to such application, the handbook, and the plan document as adopted by the board along with duly executed amendments shall comprise the subscriber agreement between the participant and the Missouri Consolidated Health Care Plan (MCHCP). Any other written materials interpreting the subscriber agreement for the benefit of members and administrators are not a part of the subscriber agreement.]* The member handbook and plan document provides the terms and conditions for membership in the Missouri Consolidated Health Care Plan (MCHCP). The member warrants that the information s/he provides in the enrollment process, whether by online enrollment in the Statewide Employee Benefit Enrollment System (SEBES), Open Enrollment, written form, or in other such organized methods, are true and accurate representation of fact.

(A) By *[applying for]* enrolling in coverage under the MCHCP, a participant agrees that—

1. The employer may deduct the cost of the premium for the employee's plan from the employee's paychecks; and

*[2. Individual and family deductibles, if appropriate, will be applied; and]*

*[3.]* 2. Any individual eligible as an employee shall not be covered as a dependent unless the employee is **under the age of twenty-six (26) or is on an approved leave of absence.**

(B) A new employee must enroll or waive coverage through SEBES at [www.sebes.mo.gov](http://www.sebes.mo.gov) within thirty-one (31) days of his/her hire date. A new employee's coverage begins on the first day of the month after enrollment. A new employee will receive a

SEBES enrollment password by email if the employee's human resource/payroll representative enters a valid email address in SEBES. Otherwise, the SEBES password will be mailed to the new employee's home address.

(C) An employee who does not enroll or waive medical coverage within the first thirty-one (31) days will be automatically enrolled in the PPO 600 Plan effective the first day of the month following the end of his/her thirty-one (31)-day eligibility period. The automatic enrollment will apply only to the employee and not to any of his/her dependents.

(D) A dependent may only be covered by one (1) parent if his/her parents are married and are both covered under an MCHCP medical plan.

(E) A member cannot be covered as a subscriber and a dependent.

(F) A dependent may have dual coverage if his/her parents are divorced or have never married and are both covered under an MCHCP medical plan.

1. MCHCP will only pay a service once regardless if the claim for the dependent's service is filed under multiple subscribers' coverage. MCHCP will process the claim and apply applicable cost-sharing using coverage through the subscriber who files the claim first. The second claim for the same services will not be covered.

2. If a provider files a claim simultaneously under both subscribers, the claim of the subscriber with the birthday first in the calendar year will be processed and applicable cost-sharing will be determined.

3. If a dependent has coverage under two (2) subscribers, the dependent will have a separate deductible and coinsurance under each subscriber.

(2) The effective date of participation shall be determined, subject to the effective date provision in subsection (2)(C), as follows:

(A) Employee Participation.

1. If *[application]* enrollment by an employee is made on or before the date of eligibility, participation shall become effective on such date of eligibility[.].

2. If *[application]* enrollment by an employee is made within thirty-one (31) days after the date of eligibility, participation may become effective on the date of eligibility or the first day of the calendar month coinciding with or following the date the *[application]* enrollment is received[, except that participation shall be retroactive to the beginning of the month for employees rehired during the month following the month participation would have terminated; and].

3. Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of employment or re-employment.

4. Employees transferred from a state department with coverage under another medical care plan into a state department covered by this plan, and their eligible dependents who were covered by the other medical care plan, are eligible for participation immediately.

5. Employees who terminate all employment with the state (not simply move from one (1) agency to another) and are rehired as a new state employee before termination of participation, and their eligible dependents who were covered by the plan, will be eligible for participation immediately.

6. Employees who terminate all employment with the state (not simply move from one (1) agency to another) and are rehired as a new state employee in the subsequent month, and their eligible dependents who were covered by the plan, will be eligible for participation retroactive to the date following termination of participation or, at the employee's choice, on the first day of the month following the employee's date of rehire. If the employee

chooses the first day of the month following his/her date of rehire, he/she will be considered a new hire and can add dependents or change plans.

[3.7]. Not limiting or excluding any of the other provisions, if [application] enrollment is not made within thirty-one (31) days of the employee's date of eligibility, they may apply for coverage only if one (1) of the following occurs:

A. Occurrence of a life event which includes marriage, birth, adoption, and placement of **adopted** children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event;

B. Loss of a spouse's employer-sponsored group coverage when the employee originally waived coverage through the plan. [Application] Enrollment must be made within sixty (60) days of the time—

(I) The employee no longer qualifies for coverage under spouse's plan;

(II) The spouse's employment terminates or he/she is no longer eligible for coverage under employer's plan;

(III) The spouse's employer-sponsored medical, dental, and/or vision plan terminates;

(IV) All employer contributions toward the spouse's plan cease; or

(V) The employee's Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or

C. Loss of eligibility for Medicaid, in which case [application] enrollment for coverage through the plan must be made within sixty (60) days of loss;

(B) Dependent Coverage. Dependent participation cannot precede the subscriber's participation except when coverage is added as a life event with birth of a child or adoption of a child at birth. The effective date for a [child] newborn is the date of birth. The subscriber and/or dependent's effective date is the first day of the calendar month coinciding with or following the date of the [application] enrollment. [Application] Enrollment for participants must be made in accordance with the following provisions. Effective dates for all dependent coverage is wholly dependent upon—

1. Proof of eligibility documentation is required for all dependents. The plan reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by the plan administrator, coverage for the applicable dependent will either be terminated or will never take effect.

A. For the addition of dependents: Required documentation should accompany the [application] enrollment for coverage, except when adding a newborn. Failure to provide acceptable documentation with the [application] enrollment will result in the dependent not having coverage until such proof is received, subject to the following:

(I) If proof of eligibility is not received with the [application] enrollment, such proof will be requested by letter sent to the subscriber. Documentation shall be received no later than thirty (30) days from the date of the letter requesting such proof. Failure to provide the required documentation in a timely manner will result in the dependent being ineligible for coverage until the next open enrollment period unless a life event occurs; and

(II) Coverage is provided for a newborn of a member from the moment of birth. **A change form, available by accessing state member information at [www.mhchp.org](http://www.mhchp.org), and proof of eligibility must be submitted prior to the birth or within the applicable time frame required by law.** [However, c/Coverage will not continue past the first thirty-one (31) days unless required documentation is received;

2. Documentation is also required when a subscriber attempts to terminate a dependent's coverage in the case of divorce or death;

3. Acceptable forms of proof of eligibility are included in the following chart:

Circumstance	Documentation
Birth of dependent(s)	<ul style="list-style-type: none"> <li>• <b>Government-issued /B/birth certificate/; or other government-issued or legally-certified proof of eligibility</b></li> <li>/• <i>Hospital certificate</i>/</li> </ul>
Addition of step-child(ren)	<ul style="list-style-type: none"> <li>• Marriage license to biological parent of child(ren); and</li> <li>• Birth <i>[or Hospital]</i> certificate for child(ren) that names the subscriber's spouse as a parent</li> </ul>
Addition of foster child(ren)	<ul style="list-style-type: none"> <li>• Placement papers in subscriber's care</li> </ul>
Adoption of dependent(s)	<ul style="list-style-type: none"> <li>• Adoption papers; <i>/or/</i></li> <li>• Placement papers; <b>or</b></li> <li>• <b>Filed petition for adoption</b></li> </ul>
Legal guardianship of dependent(s)	<ul style="list-style-type: none"> <li>• Court-documented guardianship papers (Power of Attorney is not acceptable)</li> </ul>
Newborn of covered dependent	<ul style="list-style-type: none"> <li>• <b>Government-issued /B/birth certificate for newborn listing covered dependent as parent with baby's name and birth date</b></li> </ul>
Marriage	<ul style="list-style-type: none"> <li>• Marriage license;</li> <li>• Marriage certificate; or</li> <li>• Newspaper notice of the wedding</li> </ul>
Divorce	<ul style="list-style-type: none"> <li>• Final divorce decree; or</li> <li>• Notarized letter from spouse stating he/she is agreeable to termination of coverage pending divorce</li> </ul>
Death	<ul style="list-style-type: none"> <li>• Death certificate</li> </ul>

4. For family coverage, once a subscriber is participating with respect to dependents, newly acquired dependents are automatically covered on their effective dates as long as the plan administrator is notified within thirty-one (31) days of the person becoming a dependent. First eligible dependents must be added within thirty-one (31) days of such qualifying event. The employee is required to notify the plan administrator on the appropriate form of the dependent's name, date of birth, eligibility date, and Social Security number/, *if available*. **Members who are eligible for Medicare benefits under Part A, B, or D must notify the plan administrator of their eligibility and provide a copy of the member's Social Security and Medicare cards within thirty-one (31) days of eligibility of Medicare.** Claims will not be processed until the required information is provided;

5. If an employee makes concurrent [application] enrollment for dependent participation on or before the date of eligibility or within thirty-one (31) days thereafter, participation for dependent will become effective on the date the employee's participation becomes effective;

6. When an employee participating in the plan first becomes eligible with respect to a dependent child(ren), coverage may become effective on the eligibility date or the first day of the month coinciding with or following the date of eligibility if [application] enrollment is made within thirty-one (31) days of the date of eligibility and provided any required contribution for the period is made; and

7. Survivors, retirees, vested subscribers, and long-term disability subscribers may only add dependents to their coverage when the dependent is first eligible for coverage, *[except]* **add dependents under the age of twenty-six (26) at open enrollment for the**

**2011 plan year only, add a newborn of a covered dependent, or when a dependent's employer-sponsored coverage ends due to one (1) of the following:**

- A. Termination of employment;
- B. Retirement; */and/ or*
- C. Termination of group coverage by the employer.

Coverage must have been in place for twelve (12) months immediately prior to the loss, and coverage must be requested within sixty (60) days from the termination date of the previous coverage;

(C) **Effective Date Provision.** The effective date of coverage is the first of the month coinciding with or following the eligibility date and the date the form is received by the plan. The effective date of coverage cannot be prior to the date of receipt of the enrollment form by the plan. **The effective date is determined by the date the enrollment is received by the plan administrator.** The effective date for dependent coverage is wholly dependent upon the appropriate proof of eligibility documentation being timely received by the plan (see paragraph (2)(B)1.);

(D) **[Application] Enrollment** for dependent coverage may be made within sixty (60) days when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's—

- 1. Employer-sponsored medical, dental, or vision plan terminates or coverage by the employer is no longer offered;
- 2. The employer contributions toward the premiums cease;
- 3. COBRA coverage ceases; or
- 4. A dependent no longer qualifies due to age;

(E) **[Application] Enrollment** may be made for dependent coverage within sixty (60) days *[of the event—]* **for a dependent who no longer qualifies for Medicaid;**

*[1. A Qualified Medical Child Support Order is received; or*

*2. A dependent no longer qualifies for Medicaid; or]*

(F) *[Application may be made for dependent coverage within thirty-one (31) days of an emancipated dependent regaining dependent status.]* **A Qualified Medical Child Support Order is effective the first of the month coinciding with or the month following the date the form is received by the plan.**

(3) Termination of participation shall occur on the last day of the calendar month coinciding with or following the happening of any of the following events, whichever shall occur first:

(A) Written or phone request by the employee;

(B) Failure to make any required contribution toward the cost of coverage;

(C) Entry into the armed forces of any country. With respect to an employee, membership in the National Guard or Reserves with or without two (2) consecutive full weeks of active training each year shall not be considered as entry into the armed forces; */or]*

(D) Termination of Eligibility for Participation.

1. With respect to employees, termination of participation shall occur upon termination of employment in a position covered by the MCHCP, except as **expressly specified [in sections (4) and (5)] otherwise in this rule.**

2. With respect to dependents, termination of participation shall occur upon ceasing to be a dependent as defined in this *[rule] chapter* or upon failure to provide the plan with acceptable proof of eligibility with the following exception: *[unemancipated]* mentally and/or physically handicapped children will continue to be eligible beyond age *[twenty-five (25)]* **twenty-six (26)** during the continuance of a permanent disability provided **the following documentation [satisfactory to the plan administrator] is [furnished by a physician] submitted to the plan prior to the dependent's twenty-[fifth/sixth birthday], and as requested at the discretion of the plan administrator].**

**A. The SSI Notice of Award from the Social Security Administration (SSA) verifying the dependent is entitled to and receiving disability benefits as of a specific date;**

**B. A letter from the dependent's physician describing the**

**disability and verifying that the disability predates the SSA determination; and**

**C. A current benefit verification letter from the SSA confirming the dependent is still considered disabled by SSA.**

3. Termination of employee's participation shall terminate the participation of dependents, except as specified in section *[(5)](7)*.

**4. Subscriber shall notify MCHCP when any of subscriber's dependents cease to be a dependent as defined in this chapter;**

**(E) Termination due to fraud or intentional misrepresentation; or**

**(F) A retroactive rescission will apply only to non-payment of a premium, fraud, or intentional misrepresentation.**

**(5) Terminating medical coverage is not an allowable reason to cancel dental and/or vision coverage during the year. A subscriber may only cancel dental and/or vision coverage during the year for themselves or their dependents for one (1) of the following reasons:**

- (A) Termination of employment;**
- (B) Termination of COBRA coverage;**
- (C) Retirement;**
- (D) Death;**
- (E) Leave of absence; or**
- (F) Dependent age of twenty-six (26).**

**(6) Voluntary Cancellation of Coverage.** A subscriber may retroactively cancel coverage for one (1) of the following reasons:

**(A) Cancellation of coverage on his/her spouse on the last day of the month in which a divorce is final. A copy of the divorce decree must accompany the change request; or**

**(B) Cancellation of coverage effective the last day of the prior month if the subscriber notifies MCHCP on the first calendar day of the current month.**

*[(5)](7)* Continuation of Coverage.

(A) Dependents. Termination of an active employee's participation by reason of death shall not terminate participation with respect to the surviving spouse and/or dependent children if the active employee was vested and eligible for a future retirement benefit and eligible dependents meet one (1) of the following conditions:

1. They have had coverage through MCHCP since the effective date of the last open enrollment period;

2. They have had other health insurance for the six (6) months immediately prior to the employee's death—proof of insurance is required; or

3. They have had coverage through MCHCP since they were first eligible.

(B) Employee Eligible for Retirement Benefits. Any employee who, at the time of termination of employment, met the following—

1. Eligibility criteria:

A. Coverage through MCHCP since the effective date of the last open enrollment period;

B. Other health insurance for the six (6) months immediately prior to the termination of state employment—proof of insurance is required; or

C. Coverage since first eligible;

2. Immediately eligible to receive a monthly retirement benefit from the Missouri State Employees' Retirement System, Public School Retirement System, the retirement system of a participating public entity, or the Highway Retirement System may elect to continue to participate in the plan by paying the cost of plan benefits as determined by the plan administrator. An employee must apply for continued coverage within thirty-one (31) days of the first day of the month following the date of retirement. An employee, continuing coverage under this provision, may also continue coverage for eligible dependents.



A. If a member participates in the MCHCP as a vested member, his/her dependents may also participate if they meet one (1) of the following criteria:

(I) They have had coverage through MCHCP since the effective date of the last open enrollment period;

(II) They have had other health insurance for the six (6) months immediately prior to state employment termination—proof of insurance is required; or

(III) They have had coverage since they were first eligible;

3. In the case of the death of a retiree who was maintaining dependent coverage under this provision, the dependent of the deceased retiree may continue his/her participation under the plan. However, retirees, survivors, vested subscribers, and long-term disability subscribers and their dependents are not later eligible if they discontinue their coverage at some future time, except as noted in *[(5)(B)4.] paragraph (7)(B)4.*; and

4. A vested or retired member may elect to suspend their coverage upon entry into the armed forces of any country by submitting a copy of their activation papers within thirty-one (31) days of their activation date. Coverage will be suspended the first of the month following the month of activation. Coverage may be reinstated at the same level upon discharge by submitting a copy of their separation papers and a completed enrollment form within thirty-one (31) days of their separation date. Coverage will be reinstated as of the first of the month following the month of separation.

(C) Coverage at Termination. A former employee may participate in the plan if s/he terminates employment before retirement provided s/he is a vested employee. This means s/he will be eligible for a benefit from the Missouri State Employees' Retirement System, the Public School Retirement System, the retirement system of a participating public entity, or the Missouri Department of Transportation and Highway Patrol Employees' Retirement System when s/he reaches retirement age. Coverage may also be continued by a member of the general assembly, a state official holding a statewide elective office, or an employee employed by an elected state official or member of the general assembly whose employment is terminated because the state official or member of the general assembly ceases to hold elective office. The election to participate must be made within thirty-one (31) days from the last day of the month in which employment terminated. The member must pay the full cost of coverage. However, s/he will not later be eligible if s/he discontinues coverage at some future time.

(D) Leave of Absence. An employee on approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify the plan administrator of the leave of absence and any extension of the leave of absence by submitting the required form. Any employee on an approved leave of absence who was a member of *[the Missouri Consolidated Health Care Plan] MCHCP* when the approved leave began, but who subsequently terminated participation in *[the Missouri Consolidated Health Care Plan] MCHCP* while on leave, may recommence his/her coverage in the plan at the same level (employee only or employee and dependents) upon returning to employment directly from the leave. However, eligibility is terminated for those members receiving a military leave of absence, as specified in subsection (3)(C). Coverage may be reinstated upon return from military leave. However, the former member must complete an enrollment form. Coverage under this provision is effective on the first of the month coinciding with or following the employee's return to work. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date and timely requests reinstatement of coverage.

(E) Layoff. An employee on layoff status may elect to retain eligibility to participate in the plan by paying the required contribution for a maximum of twenty-four (24) months with recertification of status at least every twelve (12) months by the employing department. Eligibility will terminate if the employee becomes eligible for health benefits as an employee of another employer. If participation termi-

nates and the employee is recalled to service, eligibility will be as a new employee.

(F) Workers' Compensation. Any person who is receiving, or is entitled to receive, Workers' Compensation benefits as a result of an injury or accident sustained in employment and who was a member of the plan at the time of becoming disabled may continue his/her coverage in the plan at the same level of participation (subscriber only or subscriber and dependents) by paying the required contributions, if the disability occurred in the employment through which the employee qualifies for membership in the plan. Any person receiving, or entitled to receive, Workers' Compensation benefits who was a member of the plan at the time of becoming disabled as a result of an injury or accident sustained in employment through which the person qualified for membership in the plan, but who subsequently terminated participation in the plan, may recommence his/her coverage in the plan at the same level (subscriber only or subscriber and dependents) upon returning to employment.

(G) Reinstatement After Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action available as a recourse through his/her employer, s/he will be allowed to reinstate his/her medical benefit retroactively to the date of dismissal. If the employee is reinstated with back pay, s/he will be responsible for paying any contribution normally made for either his/her coverage or his/her covered dependents. If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making any required contribution toward the cost of his/her medical benefits. If the employee does not purchase coverage for the period between termination and reinstatement, s/he may regain the same level of coverage s/he had prior to termination. **If the employee does not continue coverage, s/he will be considered a new hire and may enroll in the plan of his/her choice.**

*[(6)](8)* Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) In accordance with *[the]* COBRA, eligible employees and their dependents may continue their medical coverage after the employee's termination date.

1. Employees terminating for reasons other than gross misconduct or receiving a reduction in the number of hours of employment may continue coverage for themselves and their covered dependents for eighteen (18) months at their own expense.

**2. A spouse and dependents may continue coverage for up to thirty-six (36) months at their expense if the covered employee enrolls in Medicare and notifies the plan administrator within sixty (60) days of his/her Medicare entitlement.**

*[2.]3.* A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

*[3.]4.* A divorced spouse **and dependents** may continue coverage at his/her own expense for up to thirty-six (36) months if the plan administrator is notified within sixty (60) days from the date coverage would terminate.

*[4. Dependent spouse and/or child(ren) may continue coverage up to thirty-six (36) months if the covered employee retires and the dependent spouse/child(ren) has not been covered by the plan for two (2) years.]*

5. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense if the plan administrator is notified within sixty (60) days of the loss of the dependent's eligibility.

6. Employees who are disabled at termination or become disabled during the first sixty (60) days of coverage may continue coverage for up to twenty-nine (29) months.

**7. An employee who is on military leave is eligible for continued coverage for medical and dental care for the lesser of: a) twenty-four (24) months beginning on the date the leave begins; or b) the day after the date the employee fails to apply for or**



return to their position of employment following leave.

[7./8. Premiums for continued coverage will be one hundred two percent (102%) of the health plan rate, one hundred fifty percent (150%) if disabled. Once coverage is terminated under the COBRA provision, it cannot be reinstated.

[8./9. All operations under the COBRA provision will be applied in accordance with federal regulations.

[[7]](9) Missouri State Law COBRA Wrap-Around Provisions—Missouri law provides that if a member loses group health insurance coverage because of a divorce, legal separation, or the death of a spouse, the member may continue coverage until age sixty-five (65) if: a) The member continues and maintains coverage under the thirty-six (36)-month provision of COBRA; and b) The member is at least fifty-five (55) years old when COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay all of the [application] premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium. The above Cancellation of Continuation Coverage also applies to COBRA wrap-around continuation.

[[8]](10) If any retired participants or long-term disability recipients, or their [eligible] dependents, [or surviving dependents] eligible for coverage elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage. If surviving dependents do not elect to continue their coverage within thirty-one (31) days of the first day of the month following the date of death, they may not later elect to be covered.

(11) Retirees and/or dependents may continue dental and/or vision coverage into retirement without medical coverage. At retirement, employees may add themselves and/or their dependents with proof of six (6) months of dental and/or vision coverage immediately prior to their employment termination date.

(12) Medicare.

(A) If a participant eligible for Medicare who is not eligible for this plan as the primary plan is not covered by Medicare, an estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement was for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims.

(B) If a participant eligible for Medicare Part D enrolls in a Medicare Part D plan in addition to coverage under this plan, such participant's benefit may be adjusted in order for the plan to avoid liability for filing a false claim under the subsidy reimbursement portion of Medicare Part D.

(13) Communications to Members.

(A) It is the member's responsibility to ensure that the plan administrator has current contact information for the member and any dependent(s).

(B) A member must notify the plan administrator of a change in his/her mailing or email address as soon as possible, but no later than thirty (30) days of the change.

(C) It is the responsibility of all active employees and any members who elect to receive plan communication through email to ensure plan emails are not blocked as spam or junk mail by the member or by the member's service provider.

(D) Failure to update a mailing or email address may result in undeliverable mail/email of important informational material. All members will be held responsible for the content of communications mailed/emailed from the plan to members provided such communication is sent by the plan to the most recent contact information on file with the plan at the time of the mailing,

and members who fail to receive a communication as a result of failing to update his/her mailing/email address may incur additional liability or miss member opportunities relating to their covered benefits.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-2.045 Plan Utilization Review Policy.** The Missouri Consolidated Health Care Plan is amending section (1).

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan medical plans.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program [consists of four (4) parts, as described in the following] has the following components:

(A) [Precertification—The medical necessity of a non-emergency hospital admission, specified procedures as documented in the claims administrator's guidelines, and/or skilled nursing services provided on an inpatient basis must be prior authorized by the appropriate claims administrator. For emergency hospital admissions, the claims administrator must be notified within forty-eight (48) hours of the admission. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;] Prior authorization of services—The claims administrator must authorize some

services in advance. Without prior authorization, any claim that requires prior authorization will not be covered. Participants who have another primary carrier, including Medicare, are not subject to this provision. Prior authorization does not verify eligibility or payment. Prior authorizations based on a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition will not be covered.

1. The following medical services are subject to prior authorization:

A. Ambulance services for non-emergency use whether air or ground;

B. Applied behavioral analysis for autism;

C. Cardiac and pulmonary rehabilitation after thirty-six (36) visits within a twelve (12)-week period;

D. Chiropractic services after twenty-six (26) visits annually;

E. Cochlear implant device;

F. Dental care to reduce trauma and restorative services when the result of accidental injury;

G. Durable medical equipment (DME) over one thousand five hundred dollars (\$1,500) or DME rentals over five hundred dollars (\$500) per month;

H. Genetic testing or counseling;

I. Home health care and palliative services;

J. Hospice care;

K. Hospital inpatient services except for observation stays;

L. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

M. Nutritional counseling after three (3) sessions annually;

N. Orthotics over one thousand dollars (\$1,000);

O. Oxygen provided on an outpatient basis;

P. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per incident;

Q. Prostheses over one thousand dollars (\$1,000);

R. Skilled nursing facility;

S. Surgery (outpatient)—The following outpatient surgical procedures: potential cosmetic surgery, sleep apnea surgery, implantable stimulators, surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams; surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth; reduction of fractures and dislocations of the jaw; excision of exostosis of jaws and hard palate; external incisions and drainage of cellulitis; incision of accessory sinuses, salivary glands, or ducts; or frenectomy); and

T. Transplants including requests related to covered travel and lodging.

2. The following pharmacy services are subject to prior authorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications. Drugs that treat chronic, complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis. The specialty medication requires frequent dosage adjustments, clinical monitoring, and special handling and are often unavailable at retail pharmacies. The specialty medication must be filled through the claims administrator's home delivery pharmacy provider;

C. Medications that may be prescribed for several conditions including some where treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. The cost of the medication exceeds nine thousand nine hundred ninety-nine dollars and ninety-nine cents (\$9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents (\$1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents (\$149.99) for compound medications.

3. Prior authorization time frames.

A. A benefit determination for non-urgent prior authorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen (15)-calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least forty-five (45) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent prior authorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

(B) Concurrent Review—The claims administrator will *[continue to]* monitor the medical necessity of the inpatient admission *[and approve]* to certify the necessity of the continued stay in the hospital. *[Retirees and other participants for whom Medicare is the primary payor]* Participants who have another primary carrier, including Medicare, are not subject to this provision; and

*[(C) Large Case Management—Members who require long-term acute care may be offered the option of receiving the care, if appropriate, in a more cost-effective setting such as a skilled nursing facility or their own home. In some cases, this may require coverage for benefits that normally are not covered under the plan. These benefits may be provided through the approval of the claims administrator;*

*(D) Hospital Bill Audits—Certain hospital bills will be subject to review to verify that the services billed were actually provided and/or the associated billed amounts are accurate and appropriate; and*

*(E) Penalties—Members not complying with subsections (1)(A) and (B) of this rule may be subject to a financial penalty in connection with their covered benefits.]*

(C) Retrospective Review—Reviews conducted after services have been provided to a patient. The retrospective review includes an evaluation of reimbursement levels, accuracy and adequacy of documentation or coding, or settling of payment.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**EMERGENCY RESCISSION**

**22 CSR 10-2.050 Copay Plan Benefit Provisions and Covered Charges.** This rule established the policy of the board of trustees to the Copay Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

**PURPOSE:** *This rule is being rescinded because it is no longer needed.*

**EMERGENCY STATEMENT:** *This emergency rescission must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this rescission is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be registered immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the Missouri Register. This emergency rescission complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed December 20, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

**AUTHORITY:** *section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency rescission filed Dec. 20, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed rescission covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1)–(3).

**PURPOSE:** *This amendment changes the policy of the board of trustees in regard to the PPO 300 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.*

**EMERGENCY STATEMENT:** *This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further,*

*it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Deductible amount—Network: per individual each calendar year, three hundred dollars (\$300); family limit each calendar year, six hundred dollars (\$600). Non-network: per individual each calendar year, six hundred dollars (\$600); family limit each calendar year, one thousand two hundred dollars (\$1,200).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) The family deductible is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member deductibles may be used to meet the family deductible. Applicable charges received by one (1) family member may only meet the individual deductible amount.

(C) Married, active employees who are Missouri Consolidated Health Care Plan (MCHCP) subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all medical information of the family unit. Failure to report an active employee spouse when newly hired and during open enrollment will result in a separate deductible and coinsurance for both active employees.

(D) During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance. The newborn will not be subject to a separate deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital.

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(D) Claims [may also] shall be paid at ninety percent (90%) if the subscriber requires covered services that are not available through a network provider within [fifty (50)] one hundred (100) miles of his/her home. The participant must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is [not permanent] for three (3) months. After three (3) months, the participant must contact the claims administrator to reassess network availability.

(E) Preventive care—network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; *[percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits;]* **the amount the member pays due to noncompliance**; and charges above the maximum allowable amount for transplants performed by a non-network provider.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**EMERGENCY RULE**

**22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 600 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the Missouri Register. This emergency rule complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Deductible amount—Network: per individual each calendar year, six hundred dollars (\$600); family limit each calendar year, one thousand two hundred dollars (\$1,200). Non-network: per individual each calendar year, one thousand two hundred dollars (\$1,200); family limit each calendar year, two thousand four hundred dollars (\$2,400).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) The family deductible is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member deductibles may be used to meet the family deductible. Applicable charges received by one (1) family member may only meet the individual deductible amount.

(C) Married, active employees who are Missouri Consolidated Health Care Plan (MCHCP) subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all medical information of the family unit. Failure to report an active employee spouse when newly hired and during open enrollment will result in a separate deductible and coinsurance for both active employees.

(D) During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance. The newborn will not be subject to a separate deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if he/she is transferred to another hospital.

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims—are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims shall be paid at ninety percent (90%) if the subscriber requires covered services that are not available through a network provider within one hundred (100) miles of his/her home. The participant must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is for three (3) months. After three (3) months, the participant must contact the claims administrator to reassess network availability.

(E) Preventive care—network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network out-of-pocket maximum for individual—one thousand five hundred dollars (\$1,500).

(B) Network out-of-pocket maximum for family—three thousand dollars (\$3,000).

(C) Non-network out-of-pocket maximum for individual—three thousand dollars (\$3,000).

(D) Non-network out-of-pocket maximum for family—six thousand dollars (\$6,000).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(4) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed rule covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1)–(3) and (5) and adding new sections (6) and (7).

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the High Deductible Health Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri and United States Constitutions** and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Deductible amount—Network: per individual each calendar year, one thousand two hundred dollars (\$1,200); family limit each calendar year, two thousand four hundred dollars (\$2,400). Non-network: per individual each calendar year, two thousand four hundred dollars (\$2,400); family limit each calendar year, four thousand eight hundred dollars (\$4,800).

(A) The family deductible must be met before claim payments begin, applicable when two (2) or more family members are covered.

(B) If both a husband and wife are state employees covered by Missouri Consolidated Health Care Plan (MCHCP) and they both enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), they must each have a separate HSA. The maximum contribution MCHCP will make for the family is one thousand four hundred dollars (\$1,400) regardless of the number of HSAs or the number of children covered under the HDHP for either parent. MCHCP will consider married state employees as one (1) family and will not make two (2) family contributions to both spouses or one (1) family contribution and one (1) individual contribution. MCHCP will make a seven-hundred-dollar (\$700) contribution to each spouse, to total one thousand four hundred dollars (\$1,400).

(C) Married, active employees who are MCHCP subscribers need to meet only one (1) family deductible and out-of-pocket

maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all medical information of the family unit. Failure to report an active employee spouse when newly hired and during open enrollment will result in a separate deductible and coinsurance for both active employees.

(D) During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance. The newborn will not be subject to a separate deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital.

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(D) Claims [may also] shall be paid at eighty percent (80%) if the subscriber requires covered services that are not available through network provider within [fifty (50)] one hundred (100) miles of his/her home. The participant must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is [not permanent.] for three (3) months. After three (3) months, the participant must contact the claims administrator to reassess network availability.

(E) Preventive care—network claims are paid at one hundred percent (100%). Non-network claims are paid at sixty percent (60%) coinsurance after the deductible.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; [percentage amount coinsurance is reduced as a result of non-compliance with prior authorization] the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) Pharmacy benefits are subject to the [applicable medical plan] HDHP deductible and coinsurance.

(6) A member does not qualify for the HDHP if they are covered under or enrolled in any of the following types of insurance plans or programs:

(A) Medicare;

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only and dependent care section;

(D) Health reimbursement account (HRA); or

(E) The participant has veteran's benefits that have been used within the past three (3) months.

(7) A member may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009.*

Original rule filed Dec. 22, 2008, effective June 30, 2009. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Amended: Filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the *Missouri Register*.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1) and (2).

**PURPOSE:** This amendment changes the policy of the board of trustees in regard to the Medicare Supplement Plan Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

**EMERGENCY STATEMENT:** This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri* and *United States Constitutions* and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.

(1) **Eligibility**—Subscribers and dependents covered in this plan must be enrolled in Medicare, and the subscribers must be eligible to receive a monthly retirement benefit from either the Missouri State Employees' Retirement System (MOSERS) or from the Public School Retirement System (PSRS), based on years of service. A subscriber may enroll in this plan when first eligible for Medicare or during open enrollment.

(2) **Available services**—The Medicare Supplement Plan [covers coinsurance amounts on] includes the following benefits relating to Medicare Parts A and B eligible benefits after the applicable Medicare deductibles are met./:

(A) **Inpatient hospitalization**—coverage for coinsurance for day sixty-one (61) through day ninety (90);

(B) **Inpatient hospitalization**—coverage for coinsurance for life-time reserve days ninety-one (91) through one hundred fifty (150);

[(A)](C) **Inpatient [hospital care] hospitalization**—covers Medicare Part A coinsurance plus coverage for three hundred sixty-five (365) additional days after Medicare coverage ends;

[(B)](D) **Medical costs**—covers Medicare Part B coinsurance;

[(C)](E) **Blood**—covers the first three (3) pints of blood each year; and

[(D)] **Prescription drug coverage.**

(F) **Hospice**—coverage for the five percent (5%) coinsurance for Medicare-approved charges for inpatient respite care and five percent (5%) coinsurance up to a five-dollar (\$5) coinsurance maximum for prescription pain medications.

**AUTHORITY:** section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the *Missouri Register*.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1) and (2).

**PURPOSE:** This amendment changes the policy of the board of trustees in regard to the Medical Plan Benefit Provisions and Covered Charges for participation in the Missouri Consolidated Health Care Plan.

**EMERGENCY STATEMENT:** This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri* and *United States Constitutions* and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.

(1) **Benefit Provisions Applicable to the [HMO, Copay,] PPO 300,**

**PPO 600, and High Deductible Health Plan (HDHP) Plans.**

*[(A)] Subject to the plan provisions, [and] limitations, and [the written application] enrollment of the employee, the benefits are payable for covered charges incurred by a participant while covered under the plans, provided the deductible requirement, if any, is met.*

*[(B) Any deductible requirement applies each calendar year to covered charges. The requirement is met as soon as covered charges incurred in a calendar year, which are not paid in part or in whole by the plan, equals the deductible amount.*

*(C) Any family deductible requirement is met as soon as covered charges in a calendar year, which are not paid in part or in whole by the plan, equals the family deductible requirement.*

*(D) The total amount of benefits payable for all covered charges incurred non-network during an individual's lifetime shall not exceed the lifetime maximum.]*

**(2) Covered Charges Applicable to the [HMO, Copay,] PPO 300, PPO 600, and HDHP Plans.**

(A) Only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a noncovered service, and which are[/:]—

1. Prescribed by a doctor or provider for the therapeutic treatment of injury or sickness;
2. To the extent they do not exceed any limitation;
3. Not excluded by the limitations; and
4. For not more than the usual, reasonable, and customary charge, as determined by the claims administrator for the services provided, will be considered covered charges.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, reasonable, and customary, the claims administrator will consider the following:

1. The medical benefits or supplies usually rendered or prescribed for the condition; and
2. The usual, reasonable, and customary charges in the area in which services and/or supplies are provided.

(C) **A physician visit to seek a second opinion is a covered service.**

(D) **Plan benefits for the PPO 300, PPO 600, and HDHP plans are as follows:**

<b>STATE BENEFITS</b>	
<b>Allergy Serum</b> <b>Multi-dose vial</b>	
<b>No coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers or air ventilation system cleaning.</b>	
<b>Ambulance Service</b> <b>Non-emergency air or ground excluded unless prior authorization received from medical plan.</b>	
<b>Use of air ambulance or medical helicopter service from any continent returning to the U.S. is excluded.</b>	
<b>Applied Behavioral Analysis for Autism</b> <b>For children younger than age 19</b>	
<b>The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of observation, measurement and functional analysis of the relationship between environment and behavior.</b>	
<b>\$40,000 annual limit. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary.</b>	
<b>Prior authorization by medical plan required.</b>	
<b>Birth Control Prescriptions</b>	
<b>Birth Control Devices and Injections</b> <b>Administered in the physician's office.</b>	
<b>Cardiac and Pulmonary Rehabilitation</b> <b>Up to 36 visits within a 12-week period per incident</b>	
<b>Prior authorization by medical plan required after 36 visits within a 12-week period.</b>	
<b>Chelation Therapy</b> <b>Limited to treatment of lead poisoning in children as recommended by Missouri Department of Health and Senior Services.</b>	
<b>Chiropractic Services</b> <b>Up to 26 visits annually</b>	
<b>Prior authorization by medical plan required after 26 visits annually.</b>	
<b>Cochlear Implant Device</b>	
<b>Prior authorization by medical plan required.</b>	
<b>Colonoscopy</b>	
<b>Convenient Care Clinic (CCC)</b>	



**Dental Care/Accidental Injury**

**Treatment to reduce trauma and restorative services only when the result of accidental injury to sound, natural teeth and tissue that are viable, functional and free of disease. Oral surgery is covered when medically necessary as a direct result of injury, tumors or cysts. Treatment must be initiated within 60 days of accident.**

**No coverage for dental care, including oral surgery, as a result of poor dental hygiene.**

**Prior authorization by medical plan required.**

**Durable Medical Equipment (DME)/Medically Necessary Disposable Supplies**

**Basic equipment that meets medical needs. DME includes, but is not limited to, augmentative communication devices and manual and powered mobility devices. Includes repair and replacement due to normal wear and tear, if there is a change in medical condition or if growth-related. Disposable supplies that do not withstand prolonged use and are periodically replaced include, but are not limited to, colostomy and ureterostomy bags and prescription compression stockings.**

**No coverage for non-reusable disposable supplies including but not limited to bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinence pads, irrigating kits, pressure leotards, surgical leggings and support hose, over-the-counter medications and supplies including oral appliances.**

**Prior authorization by medical plan required for durable medical equipment over \$1,500 and/or rentals over \$500/month.**

**Prescription compression stockings are limited to two pairs or four individual stockings per plan year.**

**Emergency Room Services**

**If admitted to hospital, may be required to transfer to network facility for maximum benefit. Paid as network benefit.**

**Enteral Feedings (Tube Feeding)**

**Nutritional supplements that are prescribed by a physician and administered through enteral feedings, provided they are the sole source of nutrition and the member has a permanent condition, or partial nutrition during transition. This includes nutritional and electrolyte supplements and supplies related to enteral feedings (for example, feeding tubes, pumps and other materials used to administer enteral feedings).**

**Flu Shot/Nasal Spray (FluMist®)**

**Covered at 100% when administered in a network physician's office. When shot is obtained elsewhere, the member must submit a receipt and a Non-Network Flu Shot Reimbursement form to medical plan to receive reimbursement up to \$25. Multiple vaccinations covered if recommended by the Missouri Department of Health and Senior Services or by the Centers for Disease Control and Prevention.**

**Genetic Testing or Counseling**

**Genetic testing or counseling as part of treatment for a medical condition**

**No coverage for testing based on family history.**

**Prior authorization by medical plan required.**

<b>Hair Analysis and Prostheses</b> <b>Limited to prostheses and expenses for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata or alopecia totalis for children 18 years of age or younger. Annual maximum \$200. Lifetime maximum \$3,200.</b>
<b>No coverage for services related to the analysis of hair unless used as a diagnostic tool to determine poisoning.</b>
<b>Hearing Aids (Per Ear)</b> <b>Covered once every two years. Member pays coinsurance amount per hearing aid. If hearing aid cost exceeds the amount listed below, member is also responsible for charges over that amount.</b>
<b>Conventional: \$1,000</b> <b>Programmable: \$2,000</b> <b>Digital: \$2,500</b> <b>BAHA: \$3,500</b>
<b>Hearing Testing</b> <b>One hearing test per year. Additional hearing tests are covered if recommended by physician.</b>
<b>Home Health Care/Palliative Services</b>
<b>Prior authorization by medical plan required.</b>
<b>Hospice Care</b> <b>Inpatient or Outpatient</b> <b>Includes bereavement and respite care.</b>
<b>Prior authorization by medical plan required.</b>
<b>Hospital Benefits - Inpatient Room and Board</b> <b>Based on semi-private room</b> <ul style="list-style-type: none"> <li>• Medical (including outpatient services)</li> <li>• Mental Health (including outpatient services)</li> <li>• Chemical Dependency (including outpatient services)</li> <li>• Observation for Medical, Mental Health or Chemical Dependency</li> </ul>
<b>Except for observation, prior authorization by medical plan required.</b>
<b>Immunizations (Age-appropriate Adult and Pediatric)</b> <b>Specified schedule of immunizations including, but not limited to, polio, rubella, measles, mumps, tetanus, whooping cough, diphtheria, hepatitis A and B, haemophilus influenzae type B (Hib), human papillomavirus, shingles, chicken pox, meningitis and pneumonia.</b>
<b>Not covered when requested by third party or for travel.</b>
<b>Immunizations required by the Missouri Department of Health and Senior Services or recommended by the Centers for Disease Control and Prevention.</b>
<b>Injections and Infusions</b> <b>Administered in the physician's office.</b>
<b>Lab and X-ray</b>
<b>Mammograms</b> <b>One mammogram per year. Additional mammograms are covered if recommended by physician.</b>
<b>Mastectomies</b> <b>No time frame on receiving reconstructive surgery or prostheses after mastectomies necessary to restore symmetry, as recommended by physician.</b>

**Maternity Coverage**

Newborns and their mothers are allowed hospital stays of at least 48 hours after normal birth and 96 hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two-visit minimum, at least one in the home.

Prior authorization by medical plan required for maternity stays longer than 48 hours (normal delivery) or 96 hours (C-section).

**Mental Health/Chemical Dependency (Office Visit)**

**Nutrient Supplements**

Formula and low-protein modified food products recommended by physician and limited only to treatment of Phenylketonuria (PKU) or any inherited disease of amino and organic acids

**Nutritional Counseling**

Up to three sessions annually with registered dietitian, not limited by diagnosis. Up to three additional sessions considered with referral and medical diagnosis.

Prior authorization by medical plan required after three sessions annually.

**Office Visit**

Primary Care Physicians

Specialists

**Orthotics****Therapeutic Shoes for Diabetics**

Therapeutic shoes, inserts, and/or modifications to therapeutic shoes are covered if the following criteria are met:

- The patient has diabetes mellitus; and
- The patient has one or more of the following conditions:
  - Previous amputation of the other foot, or part of either foot, or
  - History of previous foot ulceration of either foot, or
  - History of pre-ulcerative calluses of either foot, or
  - Peripheral neuropathy with evidence of callus formation of either foot, or
  - Foot deformity of either foot, or
  - Poor circulation in either foot; and
- The certifying physician who is managing the patient's systemic diabetes condition has certified that indications noted in this *Therapeutic Shoes for Diabetics* section are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes.

For adult patients meeting these criteria, coverage is limited to one of the following within one year:

- One pair of custom molded shoes (which includes inserts provided with these shoes) and 2 additional pairs of inserts; or
- One pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes).

Separate inserts may be covered and dispensed independently of diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed. This footwear must meet the definitions found in this policy for depth shoes or custom molded shoes. See Orthopedic Footwear benefit.

There is no separate payment for the fitting of the shoes, inserts, or modifications or for the certification of need or prescription of the footwear.

**Spinal Orthoses**

A thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the trunk; or
- To facilitate healing following an injury to the spine or related soft tissues; or
- To facilitate healing following a surgical procedure on the spine or related soft tissue; or
- To otherwise support weak spinal muscles and/or a deformed spine.

**Helmets**

Helmets are provided when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living. These devices are not provided for use during sports-related activities.

**Cranial Orthosis for Plagiocephaly**

Plagiocephaly describes an asymmetrically shaped head. Synostotic plagiocephaly (craniosynostosis) is due to the premature closure of the cranial sutures. In non-synostotic plagiocephaly, also referred to as positional or deformational, the cranial sutures remain open. Cranial orthosis is the use of a special helmet or band on the head, which aids in molding the shape of the cranium to normal.

Dynamic orthotic cranioplasty, which may also be referred to as cranial molding, molding helmet, cranial banding, or cranial orthosis, is considered medically necessary only as an adjunct to operative therapy following surgery for craniosynostosis. Molding helmet therapy, including dynamic orthotic cranioplasty, is not a covered benefit for the non-operative management of positional or non-synotic plagiocephaly.

Initial reimbursement shall cover any subsequent revisions.

**Cervical Orthoses**

**A cervical orthosis is covered when it is ordered for one of the following indications:**

- To reduce pain by restricting mobility of the neck; or
- To facilitate healing following an injury to the cervical spine or related soft tissues; or
- To facilitate healing following a surgical procedure on the cervical spine or related soft tissue; or
- To otherwise support weak cervical muscles and/or a deformed cervical spine.

**Hip Orthoses**

**A hip orthosis is covered when it is ordered for one of the following indications:**

- To reduce pain by restricting mobility of the hip; or
- To facilitate healing following an injury to the hip or related soft tissues; or
- To facilitate healing following a surgical procedure on the hip or related soft tissue; or
- To otherwise support weak hip muscles and/or a hip deformity.

**Knee Orthoses**

**A knee orthosis is covered when it is ordered for one of the following indications:**

- To reduce pain by restricting mobility of the knee; or
- To facilitate healing following an injury to the knee or related soft tissues; or
- To facilitate healing following a surgical procedure on the knee or related soft tissue; or
- To otherwise support weak knee muscles and/or a knee deformity.

**These devices are not provided solely for use during sports-related activities.**

**Ankle-Foot/Knee-Ankle-Foot (AFO) Orthoses**

**AFOs Not Used During Ambulation**

**A static AFO is covered if the following criteria are met:**

- Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a non-fixed contracture); and,
- Reasonable expectation of the ability to correct the contracture; and,
- Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and,
- Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; OR
- The patient has plantar fasciitis.

**If a static AFO is used for the treatment of a plantar flexion contracture, the pre-treatment passive range of motion must be measured with a goniometer and documented in the medical record. There must be documentation of an appropriate stretching program carried out by professional staff or caregiver. A static AFO and replacement interface will be denied as not medically necessary if the contracture is fixed. A static AFO and replacement interface will be denied as not medically necessary for a patient with a foot drop but without an ankle flexion contracture. A component of a static AFO that is used to address positioning of the knee or hip will be denied as not medically necessary because the effectiveness of this type of component is not established.**

**If a static AFO is covered, a replacement interface is covered as long as the patient continues to meet indications and other coverage rules for the splint. Coverage of a replacement interface is limited to a maximum of one (1) per 6 months. Additional interfaces will be denied as not medically necessary. A foot drop splint/recumbent positioning device and replacement interface will be denied as not medically necessary in a patient with foot drop who is non-ambulatory because there are other more appropriate treatment modalities.**

**AFOs and KAFOs Used During Ambulation**

**AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally.**

**Knee-ankle-foot orthoses (KAFO) are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required.**

**If the basic coverage criteria for an AFO or KAFO are not met, the orthosis will be denied as not medically necessary. AFOs and KAFOs that are molded-to-patient-model, or custom-fabricated, are**

covered for ambulatory patients when the basic coverage criteria listed above and one of the following criteria are met:

- The patient could not be fit with a prefabricated AFO, or
- The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months), or
- There is a need to control the knee, ankle or foot in more than one plane, or
- The patient has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury, or
- The patient has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

Current Procedural Terminology (CPT) L-coded additions to AFOs and KAFOs will be denied as not medically necessary if either the base orthosis is not medically necessary or the specific addition is not medically necessary.

#### **Foot Orthosis**

Custom, removable foot orthoses are considered medically necessary for members who meet the following criteria:

- Member has any of the following conditions:
  - Adults (skeletally mature feet):
    - Acute plantar fasciitis
    - Acute sport-related injuries (including: diagnoses related to inflammatory problems; e.g., bursitis, tendonitis)
    - Calcaneal bursitis (acute or chronic)
    - Calcaneal spurs (heel spurs)
    - Conditions related to diabetes (see section above on therapeutic shoes for diabetes for a complete list of medically necessary diagnoses)
    - Inflammatory conditions (i.e., sesamoiditis; submetatarsal bursitis; synovitis; tenosynovitis; synovial cyst; osteomyelitis; and plantar fascial fibromatosis)
    - Medial osteoarthritis of the knee (lateral wedge insoles)
    - Musculoskeletal/arthropathic deformities (including: deformities of the joint or skeleton that impairs walking in a normal shoe; e.g. bunions, hallux valgus, talipes deformities, pes deformities, anomalies of toes)
    - Neurologically impaired feet (including: neuroma; tarsal tunnel syndrome; ganglionic cyst; and neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease)
    - Vascular conditions (including: ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), chronic thrombophlebitis).
  - Children (skeletally immature feet):
    - Hallux valgus deformities
    - In-toe or out-toe gait
    - Musculoskeletal weakness (e.g., pronation, pes planus)
    - Structural deformities (e.g., tarsal coalitions)
    - Torsional conditions (e.g., metatarsus adductus, tibial torsion, femoral torsion)

#### **Orthopedic Footwear**

Orthopedic footwear is covered for adults if it is an integral part of a covered leg brace. Oxford shoes are covered in these situations. Other shoes, e.g. high top, depth inlay or custom for non-diabetics, etc., are also covered if they are an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace. Heel replacements, sole replacements, and shoe transfers involving shoes on a covered brace are also covered. Inserts and other shoe modifications are covered if they are on a shoe that is an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace.

**A shoe and related modifications, and heel/sole replacements, are covered only when the shoe is an integral part of a brace. A matching shoe which is not attached to a brace is non-covered.**

**Shoes which are incorporated into a brace must be billed by the same supplier billing for the brace.**

**Upper Limb Orthoses**

**An upper limb orthosis is covered when it is ordered for one of the following indications:**

- **To reduce pain by restricting mobility of the joint(s)**
- **To facilitate healing following an injury to the joint(s) or related soft tissues**
- **To facilitate healing following a surgical procedure on the joint(s) or related soft tissue**

**Elastic Supports**

**Elastic supports are covered when they are ordered for one of the following indications:**

- **Severe or incapacitating vascular problems, such as**
  - **acute thrombophlebitis**
  - **massive venous stasis**
  - **pulmonary embolism**
- **Venous insufficiency**
- **Varicose veins**
- **Edema of lower extremities**
- **Edema of pregnancy**
- **Lymphedema**

**Trusses**

**Trusses are covered when a hernia is reducible with the application of a truss.**

**Orthotic-Related Supplies**

**Orthotic-related supplies are covered when the device with which it is used is covered and they are necessary for the function of the orthotic device.**

**Cast Boot, Post-Operative Sandal or Shoe, Healing Shoe**

**A cast boot or post-operative sandal or shoe is covered when it is medically necessary for one of the following indications:**

- **to protect a cast from damage during weight-bearing activities following injury or surgery;**
- **to provide appropriate support and/or weight-bearing surface to a foot following surgery;**
- **to promote good wound care and healing via appropriate weight distribution and foot protection; or**
- **when the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.**

**Specific Exclusions**

**Non-covered devices and supplies include, but are not limited to, all of the following:**

- **Experimental or Investigational devices**
- **Items for the patient's comfort or convenience or for the convenience of the patient's caregiver(s)**
- **Items to have on hand for backup or duplicates to have available at various locations**
- **Devices and supplies for residents of nursing facilities**
- **Equipment or supplies covered by another agency**

**Replacing Orthotic Devices**

**When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item. A replacement is subject to review of medical necessity. The plan will take into account the anticipated life expectancy of the device.**

**Prior authorization by medical plan required for orthotics over \$1,000**

**Outpatient Diagnostic Procedures**

**Including, but not limited to, diagnostic sigmoidoscopies, endoscopies, sleep studies, ultrasounds, electroencephalograms (EEGs) and electrocardiograms (EKGs)**

**Oxygen  
Outpatient**

Go to **DURABLE MEDICAL EQUIPMENT** in this section.

**Prior authorization by medical plan required.**

**Physical, Speech and Occupational Therapy and Rehabilitation Services - Outpatient**

Up to 60 combined visits allowed per incident if showing significant improvement. Aquatic therapy must be performed by physical therapist to be covered.

**Speech Therapy:**

Covered as medically necessary for either of the following:

- A prescribed course of speech therapy by an appropriate healthcare provider for the treatment of a severe impairment of speech/language and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests that measure the extent of the impairment, performance deviation, and language and pragmatic skills assessment levels.
- A prescribed course of voice therapy by an appropriate healthcare provider for a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery).

When all of the following criteria are met:

- The treatment being recommended has the support of the treating physician;
- The therapy being ordered requires the one-to-one intervention and supervision of a speech-language pathologist;
- The therapy plan includes specific tests and measures that will be used to document significant progress every two weeks;
- Meaningful improvement is expected from the therapy and
- The treatment includes a transition from one-to-one supervision to an individual or caregiver provided maintenance program upon discharge.

Speech or voice therapy is not covered in any of the following situations:

- Any computer-based learning program for speech or voice training purposes
- School speech programs
- Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy)
- Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs)
- Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver
- Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work
- Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences
- Therapy or treatment provided to improve or enhance job, school or recreational performance
- Long-term rehabilitative services when significant therapeutic improvement is not expected

**Physical Therapy:**



**Covered as a prescribed course of physical therapy by an appropriate healthcare provider as medically necessary when all of the following criteria are met:**

- The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect or surgery;
- The program is expected to result in significant therapeutic improvement over a clearly defined period of time and
- The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.

**Physical therapy is not covered for the following:**

- Treatment provided to prevent or slow deterioration in function or prevent reoccurrences
- Treatment intended to improve or maintain general physical condition
- Long-term rehabilitative services when significant therapeutic improvement is not expected
- Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g. occupational therapy)
- Work hardening programs
- Back school
- Vocational rehabilitation programs and any program with the primary goal of returning an individual to work
- Group physical therapy (because it is not one-on-one, individualized to the specific person's needs)
- Services for the purpose of enhancing athletic performance or for recreation

**Occupational Therapy:**

**Covered as prescribed course of occupational therapy by an appropriate healthcare provider as medically necessary when all of the following criteria are met:**

- The program is designed to improve or compensate for lost or impaired physical functions, particularly those impacting activities of daily living, resulting from illness, injury, congenital defect, or surgery;
- The program is expected to result in significant therapeutic improvement over a clearly defined period of time and
- The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.

**Occupation Therapy is not covered for the following:**

- Treatment provided to prevent or slow deterioration in function or prevent reoccurrences
- Treatment intended to improve or maintain general physical condition
- Long-term rehabilitative services when significant therapeutic improvement is not expected
- Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g. physical therapy)
- Work hardening programs
- Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work
- Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs)
- Driving safety/driver training

**Prior authorization by medical plan required after 60 combined visits per incident.**

**Physician Charges**

**Preventive Services**

- Services recommended by the U.S. Preventive Services Task Force (categories A and B)
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration
- Preventive care and screenings for women supported by the Health Resources and Services Administration

**Annual physical exams (Well man, woman and child) -  
one per calendar year**

**Age-specific cancer screenings:**

- Mammograms
- Pap smears
- Prostate cancer screenings
- Colorectal screenings
- Colonoscopy and sigmoidoscopy screenings

**For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.**

**Prostheses (Prosthetic Devices)**

**Basic equipment that meets medical needs**

**Repair and replacement not covered unless due to normal wear and tear, if there is a change in medical condition or if growth-related.**

**Prior authorization by medical plan required for prostheses over \$1,000.**

**Skilled Nursing Facility**

**Benefits are limited to 120 days per calendar year.**

**Prior authorization by medical plan required.**

**Surgery (Inpatient and Outpatient)**

**Includes sterilization**

**Prior authorization by medical plan required for outpatient surgeries:**

- Potential cosmetic surgery
- Sleep Apnea surgery
- Implantable Stimulators
- All outpatient surgeries with procedure codes ending in T (temporary codes used for data collection, experimental, investigational or unproven surgeries)
- Outpatient spinal surgeries including but not limited to artificial disc replacement, fusions, non-pulsed radiofrequency denervation, vertebroplasty/kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure.

**Oral surgery**

- Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological exams
- Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth
- Reduction of fractures and dislocations of the jaw
- Excision of exostosis of jaws and hard palate
- External incision and drainage of cellulitis
- Incision of accessory sinuses, salivary glands or ducts
- Frenectomy

**Transplants**

**When neither experimental nor investigational and medically necessary: bone marrow, cornea, kidney, liver, heart, lung, pancreas, intestinal or any combination. Includes services related to organ procurement and donor expenses if not covered under another plan.**

**Contact medical plan for arrangements, prior authorization and transplant network.**

**Travel, if approved, is limited to \$10,000 maximum per transplant.**

**Network**

**Includes travel and lodging allowance for recipient and his or her immediate family travel companion (younger than 19, both parents) if transplant facility is more than 100 miles from residence.**

**Lodging: Maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to [www.gsa.gov](http://www.gsa.gov) for per diem rates.**

**Travel: IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).**

**Meals: Not covered.**

**Prior authorization by medical plan required.**

**Non-network**

**Reimbursement limited to maximum schedule. Charges above the maximum are your responsibility and do not apply to your deductible or out-of-pocket maximum.**

**Travel, lodging and meals not covered.**

**Prior authorization by medical plan required.**

**Urgent Care**

**Paid as network benefit.**

**Vision - Routine Exam (Including refractions)**

**One per covered person per calendar year.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan, and HDHP[, Copay Plan, and HMO Plan] Limitations.** The Missouri Consolidated Health Care Plan is amending the rule title and the purpose; deleting sections (2), (33), (48), (50), (52), and (57); adding sections (3), (6), (7), (9)–(11), (15), (16), (30), (33), (37), (41), (42), (48), (54), (56), and (63); amending sections (12), (18)–(20), (35), (40), (43), (49), (59), (64), and (65); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to limitations of the PPO 300 Plan, PPO 600 Plan, and HDHP Limitations of the Missouri Consolidated Health Care Plan.*

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 300 Plan, PPO 600 Plan, and HDHP[, Copay, and HMO Plan] Limitations of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges[, or within any of the sections of this rule]. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein.

[(2) If applicable, all hospitalizations, outpatient treatment for chemical dependency, or mental and nervous disorder that do not receive prior authorization as described in 22 CSR 10-2.045, reimbursement will be reduced by ten percent (10%) of reasonable and customary charges.]

[(3)](2) Abortion—other than situations where the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

(3) Acts of war—injury or illness caused, or contributed to, by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

(6) Assistant surgeon services—not covered unless determined to meet the clinical eligibility for coverage under the plan.

(7) Athletic trainer services—services by a licensed athletic trainer not covered.

[(6)](8) Autopsy.

(9) Bariatric procedures—not covered except for members who have undergone bariatric procedures before December 31, 2010, that were approved by the medical plan will receive follow-up care until December 31, 2011. Revisions and corrections of bariatric procedures are covered only when the revision is used to treat life-threatening complications (e.g., wound infection, abscess, dehiscence, gastric leaking, and embolism).

(10) Blood donor expenses—not covered.

(11) Blood pressure cuffs/monitors—not covered.

[(7)](12) Blood storage[, ]—not covered, including whole blood, blood plasma, and blood products.

[(8)](13) Breast augmentation mammoplasty—not covered unless associated with breast surgery following a medically necessary mastectomy incurred secondary to active disease.

[(9)](14) Care received without charge.

(15) Charges resulting from the failure to appropriately cancel a scheduled appointment.

(16) Childbirth classes.

[(10)](17) Comfort and convenience items.

[(11)](18) Cosmetic, plastic, reconstructive, or restorative surgery—unless medically necessary to repair a functional disorder caused by disease[, ] or injury, or congenital defect or abnormality (for a participant under the age of nineteen (19)), or to restore symmetry following a mastectomy.

[(12)](19) Custodial or domiciliary care—includes services and supplies that assist members in the activities of daily living like walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets [and]; supervision of medication that is usually self-administered; or other services that can be provided by persons without the training of a health care provider.

[(13)](20) Dental—treatment must be initiated within sixty (60) days of accident. Limited to treatment of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of disease. Oral surgery is covered only when medically necessary as a direct result from injury, tumors, or cysts. Dental care, including oral

surgery, as a result of poor dental hygiene is not covered. Extractions of bony or partial bony impactions are excluded.

**[(14)](21)** Durable medical equipment and disposable supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings, and support hose. Over-the-counter medications and supplies. Prescription compression stockings are limited to two (2) pairs of four (4) individual stockings per plan year.

**[(15)](22)** Educational or psychological testing—not covered unless part of a treatment program for covered services.

**[(16)](23)** Examinations requested by a third party.

**[(17)](24)** Excessive charges—any otherwise eligible expenses that exceed the maximum allowance or benefit limit.

**[(18)](25)** Exercise equipment.

**[(19)](26)** Experimental services or investigational services—experimental or investigational services, procedures, supplies, or drugs as determined by the claims administrator are not covered, except clinical trials for cancer treatment as specified by law.

**[(20)](27)** Eye glasses and contact lenses—charges incurred in connection with the fitting of eye glasses or contact lenses except for initial placement immediately following cataract surgery.

**[(21)](28)** Eye services—health services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

**[(22)](29)** Services obtained at a government facility—not covered if care is provided without charge.

**(30) Gender reassignment—health services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment.**

**[(23)](31)** Hair analysis, wigs, and hair transplants—services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also, hairstyling wigs, hairpieces, and hair prostheses, including those ordered by a participating provider, are not covered. Such items and services are not covered except for members ages eighteen (18) and under with alopecia as specified by law. Subject to two hundred dollar (\$200) annual maximum and three thousand two hundred dollar (\$3,200) lifetime maximum.

**[(24)](32)** Health and athletic club membership—including costs of enrollment.

**(33) Home births.**

**[(25)](34)** Immunizations requested by third party or for travel.

**[(26)](35)** Infertility **treatment.**—*Infertility treatments are limited to in-vivo (intrauterine, intracervical, intravaginal fertilization). Those health services and associated expenses for the treatment of infertility are not covered, including reversal of voluntary sterilization, intracytoplasmic sperm injection (ICSI), in vitro fertilization, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT) procedures; embryo transport; donor sperm and related cost for collec-*

*tion; no cryopreservation of sperm or eggs; and non-medically necessary amniocentesis.]*

**[(27)](36)** Level of care, if greater than is needed for the treatment of the illness or injury.

**(37) Long-term care.**

**[(28)](38)** Medical care and supplies—not to the extent that they are payable under—

(A) A plan or program operated by a national government or one (1) of its agencies; or

(B) Any state's cash sickness or similar law, including any group insurance policy approved under such law.

**[(29)](39)** Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the participant, such as a spouse, parent, child, sibling, or brother/sister-in-law.

**[(30)](40)** Military service connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

**(41) Never events—twenty-eight (28) occurrences on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting. They are defined as adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.**

**(42) Nocturnal enuresis alarm.**

**[(31)](43)** Non-network providers—subject to **higher** deductible and non-network coinsurance.

**[(32)](44)** Not medically necessary services—with the exception of preventive services.

**[(33)** *Obesity—medical and surgical intervention is not covered, unless the member meets the definition of severe morbid obesity as defined in 22 CSR 10-2.010 and satisfies all requirements described in the plan. Bariatric surgery will only be covered when prior authorization is received from the medical plan.*

(A) *Bariatric surgery additional qualifying criteria—*

1. *Presence of severe morbid obesity that has persisted for at least five (5) years defined as body mass index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions approved by the plan based on clinical review;*

2. *Member must be eighteen (18) years of age or older;*

3. *Documented evidence of at least two (2) failed attempts at weight loss each with a minimum duration of at least six (6) months with the member achieving at least a ten percent (10%) weight loss and meeting the following additional criteria: one (1) attempt must be in a physician-supervised weight loss program and fully documented in the physician's record; the program must use a multidisciplinary approach including dietician consultation, low-calorie diet, increased physical activity, and behavioral modification; nationally recognized program such as Jenny Craig or Weight Watchers (This does not include self-directed low-calorie diets such as the Atkins Diet or South Beach Diet.);*

and the most recent attempt must have been within the twelve (12)-month period prior to the requested surgery;

4. Documented evidence the member is on a nutrition and exercise program immediately prior to the surgery request;

5. Evidence the member and the attending physician have a life-long plan for compliance with lifestyle modification requirements;

6. Documentation the member has completed a psychological evaluation and, if appropriate, behavior modification and should be free of major psychiatric diagnosis or a current behavior which would significantly reduce long-term effectiveness of the proposed treatment; and

7. Procedure must be performed at a Centers of Excellence (COE) facility for Bariatric Surgery as determined by the Centers for Medicare and Medicaid Services.

(B) Network services are limited to one (1) operative procedure for the treatment of obesity per lifetime. Non-network obesity services are not covered.

(C) Revisions and corrections of bariatric procedures are covered only when the revision or correction is used to treat life-threatening complications (e.g., wound infection, abscess, dehiscence, gastric leaking, and embolism). Coverage is limited to the following bariatric procedures: Roux-en-Y Gastric Bypass—open and laparoscopic (RYGBP), Laparoscopic Adjustable Gastric Banding (LAGB), and Open and Laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS).]

[(34)](45) Orthognathic surgery.

[(35)](46) Orthoptics.

[(36)](47) Other charges—no coverage for charges that would not be incurred if the subscriber was not covered. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are disallowed. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan. Miscellaneous service charges—telephone consultations, charges for failure to keep scheduled appointment (unless the scheduled appointment was for a mental health service), or any late payment charge.

(48) Outpatient birthing centers.

[(37)](49) Over-the-counter medications—except for insulin and drugs recommended by the U.S. Preventive Services Task Force (Categories A and B) as prescribed by a physician and included on the formulary through the pharmacy benefit.

[(38)](50) Over-the-counter supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings, and support hose.

[(39)](51) Physical fitness.

[(40)](52) Physical, speech, and occupational therapy—health services and associated expenses for development delay. Treatment for disorders relating to delays in learning, motor skills, and communications.

[(41)](53) Private duty nursing.

(54) Prognathic and maxillofacial surgery.

[(42)](55) Prosthetic repair or replacement—not covered unless due to normal wear and tear, if there is a change in medical condition, if growth related, or medically necessary.

(56) Self-inflicted injuries—not covered unless related to a mental diagnosis.

[(43)](57) Services not specifically included as benefits.

[(44)](58) Services rendered after termination of coverage—those services otherwise covered under the agreement, but rendered after the date coverage under the agreement terminates, including services for medical conditions arising prior to the date individual coverage under the agreement terminates.

[(45)](59) Stimulators (for bone growth)—not covered unless prior authorized by claims administrator and clinical eligibility is met.

[(46)](60) Surrogacy—pregnancy coverage is limited to plan member.

[(47)](61) Temporo-Mandibular Joint Syndrome (TMJ).

[(48) Third-party examinations.]

[(49)](62) Tobacco cessation—patches and gum are not covered. [There is a limited benefit available under the pharmacy benefit.]

(63) Transplant benefits at a non-network facility. Non-network facility charges and payments for transplants are limited to the following maximum only:

- (A) Allogenic Bone Marrow—\$143,000;
- (B) Autologous Bone Marrow—\$121,000;
- (C) Heart—\$128,000;
- (D) Heart and Lung—\$133,000;
- (E) Lung—\$151,000;
- (F) Kidney—\$54,000;
- (G) Kidney and Pancreas—\$97,000; and
- (H) Liver—\$153,000.

[(50) Transplants—double listing—payment only for one (1) evaluation up to time of actual transplant.]

[(51)](64) Transplants—travel expense—requires authorization from medical plan. Limited to ten thousand dollar (\$10,000) maximum per transplant when accessing network services. Travel expenses include travel and lodging allowance for recipient and his/her immediate family travel companion. When a participant is younger than nineteen (19) years of age, travel expenses are covered for both parents. Transplant facility must be more than one hundred (100) miles from the recipient's residence. Meals are not covered.

[(52) Transsexual surgery—health services and associated expenses in the transformation operations regardless of any diagnosis or gender role disorientation or psychosexual orientation or any treatment or studies related to sex transformation. Also excludes hormonal support for sex transformation.]

[(53)](65) Travel expenses—not covered [unless authorized by claims administrator] except for transplants in a network facility.

[(54)](66) Trimming of nails, corns, or calluses—not covered except for persons being treated for diabetes, peripheral vascular disease, or blindness.

[(55)](67) Usual, Customary, and Reasonable (UCR)—charges exceeding UCR are not covered, as applicable to the non-network benefit.

[(56)](68) Vitamins and nutrients—limited to prenatal agents for pregnancy, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents through the pharmacy benefit.

[(57) War or insurrection—liability to provide services limited in the event of a major disaster, epidemic, riot, or other circumstances beyond the control of the plan.]

[(58)](69) Workers' compensation—charges for services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other **similar** legislation [of similar program].

**AUTHORITY:** section 103.059, RSMo 2000 and section 103.080.3, RSMo Supp. [2009] 2010. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.

## Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

### Division 10—Health Care Plan Chapter 2—State Membership

#### EMERGENCY RESCISSION

**22 CSR 10-2.064 HMO Summary of Medical Benefits.** This rule established the policy of the board of trustees in regard to the HMO Summary of Medical Benefits of the Missouri Consolidated Health Care Plan.

**PURPOSE:** This rule is being rescinded because it is no longer needed.

**EMERGENCY STATEMENT:** This emergency rescission must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this rescission is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be registered immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rescission complies with the protections extended by the **Missouri and United States Constitutions** and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed December 20, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.

**AUTHORITY:** section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Dec. 20, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.

## Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

### Division 10—Health Care Plan Chapter 2—State Membership

#### EMERGENCY AMENDMENT

**22 CSR 10-2.075 Review and Appeals Procedure.** The Missouri Consolidated Health Care Plan is deleting section (1), amending and renumbering sections (2)–(6), and adding new sections (1) and (3).

**PURPOSE:** This amendment changes the policy of the board of trustees in regard to review and appeals procedures for participation in the Missouri Consolidated Health Care Plan.

**EMERGENCY STATEMENT:** This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri and United States Constitutions** and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and was terminated on January 20, 2011.

[(1) When any participant shall suffer any injury or sickness giving rise to claim under these rules, s/he shall have free choice of providers practicing legally in the location in which service is provided to the end that a provider/patient relationship shall be maintained. Reimbursement will be in accordance with the benefit provisions of the type of coverage chosen by the participant.]

**(1) Medical and Pharmacy Service Appeals.** There is an internal appeals process through the claims administrators for urgent care, pre-service, and post-service claims that a member may request reconsideration of an adverse benefit determination. There is a two (2)-level internal appeal process for medical services and a one (1)-level appeal process for pharmacy services. Once the internal appeal process is complete, the member may further appeal through an external review process.



(A) Claims are divided into two (2) types: pre-service and post-service claims.

1. Pre-service claims are requests for approval that the health plan contractor or claims administrator requires a member to obtain before getting medical care, such as prior authorization or a decision on whether a treatment or procedure is medically necessary.

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than fifteen (15) days from the date the health plan contractor or claims administrator has received the claim. The health plan contractor or claims administrator may extend the time period up to an additional fifteen (15) days if, for reasons beyond the claims administrator's control, the decision cannot be made within the first fifteen (15) days. The health plan contractor or claims administrator must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the health plan contractor or claims administrator. The health plan contractor or claims administrator then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

B. Urgent care claims are a special type of pre-service claim that requires a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within twenty-four (24) hours and will follow-up with written confirmation of the decision.

2. Post-service claims are all other claims for benefits including claims after medical services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

A. Post-service claims must be decided within a reasonable period of time, but not later than thirty (30) days after the claims administrator has received the claim. If, because of reason beyond the health plan contractor or claims administrator's control, more time is needed to review the claim, the claims administrator may extend the time period up to an additional fifteen (15) days. The health plan contractor or claims administrator must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the health plan contractor or claims administrator. The claims administrator then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

[(2)]B. The [plan administrator, agent] health plan contractor or claims administrator, upon receipt of a notice of request, shall furnish to the employee the forms as are usually furnished for filing proof[s] of loss. If the forms are not furnished within thirty (30) days after the giving of such notice, the employee shall be deemed to have complied with the requirement as to proof of loss upon submitting, within the time fixed for filing proof[s] of loss, written proof covering the occurrence, the character, and the extent of the loss for which request is made.

[(3)]C. Written proof of claims incurred should be furnished to the health plan contractor or claims administrator as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the claims administrator before they are paid.

[(4)]D. In the case of medical benefits, the health plan contractor or claims administrator will send written notice of any amount applied toward the deductible as well as any payments made. The claims administrator may also send a request for additional information or material to support the claim, along with reasons why this information is necessary.

E. The member is entitled to receive, upon written request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim in question.

F. A first level appeal for medical and pharmacy services of an adverse benefit determination shall be submitted in writing within one hundred eighty (180) days of the date on the original claim decision notice.

(I) Submit the first level appeal to the health plan contractor or claims administrator in writing to—

(a) UMR Claims Appeal Unit, PO Box 30546, Salt Lake City, UT 84130-0546;

(b) Mercy Health Plans, Attn: Corporate Appeals, 14528 S. Outer 40 Road, Suite 300, Chesterfield, MO 63017; or

(c) Express Scripts, Clinical Appeals—MH3, 6625 West 78th Street, BL0390, Bloomington, MN 55439 or fax to 1-877-852-4070.

(II) Include any additional information or documentation to support the reason the original claim decision should be overturned.

(III) The first level appeal will be reviewed by the health plan contractor or claims administrator who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved.

(IV) The first level appeal shall be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the health plan contractor or claims administrator received the first level appeal request.

G. An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care.

(I) Submit the expedited appeal to the health plan contractor or claims administrator by telephone or fax to—

(a) UMR telephone 1-866-868-7758 or by fax to 1-866-912-8464, Attention: Appeals Unit;

(b) Mercy Health Plans telephone 1-800-830-1918, ext. 2394 or by fax to 1-314-214-3233, Attention: Corporate Appeals; or

(c) Express Scripts, Clinical Appeals—MH3, 6625 West 78th Street, BL0390, Bloomington, MN 55439 or fax to 1-877-852-4070.

(II) The expedited appeal will be reviewed by the health plan contractor or claims administrator who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved.

(III) The expedited appeal will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision within three (3) working days of providing notification of the determination.

H. A second level appeal for medical services shall be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination.

(I) Submit the second level appeal to the health plan contractor or claims administrator in writing to—

(a) UMR Claims Appeal Unit, PO Box 8086, Wausau, WI 54402-8086; or

(b) Mercy Health Plans, Attn: Corporate Appeals, 14528 S. Outer 40 Road, Suite 300, Chesterfield, MO 63017.

(II) Include any additional information or documentation to support the reason the first level appeal decision should be overturned.

(III) The second level appeal will be reviewed by the health plan contractor or claims administrator who will have someone review the appeal who was not involved in the original decision or first level appeal and will consult with a qualified medical professional if a medical judgment is involved.

(IV) The second level appeal shall be responded to in writing to the member within sixty (60) days for post service claims and thirty (30) days for pre-service claims from the date the claims administrator received the second level appeal request.

*[(5)](2)* All members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the health plan contractor or claims administrator applicable to the member. *[Appeals to the health plan contractor or claims administrator must be made in writing within one hundred eighty (180) days of receiving the denial or notice which gave rights to the appeal. Only after these procedures have been exhausted may the member appeal directly to the Missouri Consolidated Health Care Plan to review the decision of the health plan contractor or claims administrator.]* Following the completion of the internal appeal process, an external appeal for medical and pharmacy services is available through the Missouri Department of Insurance, Financial Institutions and Professional Registration. Submit written request for an external appeal to Missouri DIFP, Attn: Consumer Affairs, PO Box 690, Jefferson City, MO 65102-0690. An external appeal request may be requested online at <https://insurance.mo.gov/consumer/complaints/consumercomplaint.php> and may also be faxed to 573-526-4898.

(3) Dental and Vision Plan Appeals. Appeals involving services from the dental and vision plans are solely through the dental and vision plan contractor.

*[(A)](4)* *[Appeals to MCHCP shall be submitted in writing within forty-five (45) days of receiving the final decision from the member's health care plan contractor or claims administrator, specifically identifying the issue to be resolved.]* Administrative appeals involve issues regarding MCHCP eligibility, plan effective dates, premium payments, Lifestyle Ladder program, and plan choices. Administrative appeals shall be submitted in writing *[as soon as possible following]* within one hundred eighty (180) days from the date of the notice of administrative decision or written *[or verbal notice of an MCHCP staff]* denial of the member's administrative request.

(A) All *[appeals and]* administrative appeals shall be addressed to:

Attn: Appeal  
Board of Trustees  
Missouri Consolidated Health Care Plan  
PO Box 104355  
Jefferson City, MO 65110-4355

(B) The board may, in its discretion, choose to conduct a hearing regarding a member's administrative appeal. If the board decides a hearing is needed to render a decision, it may utilize a hearing officer or committee to conduct a fact-finding hearing and make proposed findings of fact and conclusions of law. In such cases—

1. The hearing will be scheduled by the MCHCP;
2. The parties to the hearing will be the insured and the applicable health plan or MCHCP staff in self-insured situations;
3. All parties shall be notified in writing of the date, time, and location of the hearing;
4. All parties shall have the right to appear at the hearing and

submit written or oral evidence. The appealing party shall be responsible for all copy charges incurred by MCHCP in connection with any documentation that must be obtained through the MCHCP. These fees will be reimbursed should the party prevail in his/her appeal. They may cross-examine witnesses. They need not appear and may still offer written evidence. The strict rules of evidence shall not apply;

5. The party appealing to the board shall carry the burden of proof; and

6. The hearing officer shall propose findings of fact and conclusions of law, along with its recommendation, to the board. Copies of the summary, findings, conclusions, and recommendations shall be sent to all parties.

(C) The board may, but is not required to, review the transcript of the hearing and solicit additional evidence and argument. It will review the summary of evidence and the proposed findings of fact and conclusions of law and shall then issue its final decision on the matter.

1. All parties shall be given a written copy of the board's final decision.

2. All parties shall be notified that, if they feel aggrieved by the final decision, they shall have the right to seek judicial review of the decision as provided by Missouri law.

(D) Administrative decisions made solely by MCHCP may be appealed directly to the board of trustees, by either a member or health plan contractor providing a fully-insured product.

1. All the provisions of this rule, where applicable, shall apply to these appeals.

2. The parties to such appeal shall be the appellant and the MCHCP shall be respondent.

3. The appellant, if aggrieved by the final decision of the board, shall have the right of appeal as stated in subsection *[(5)](C)* *(4)(C)* herein.

*[(6)](E)* In reviewing administrative appeals, notwithstanding any other rule, the board and/or staff may grant any administrative appeal/s/ when there is credible evidence to support approval under the following guidelines/.

*[(A)]1.* Newborns—If a member currently has coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within three (3) months of the child's date of birth.

*[(B)]2.* Agency error—MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office, the MCHCP, or plan offered by MCHCP that was no fault of the member.

*[(C)]3.* Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year.

*[(D)]4.* Non-payment—MCHCP may allow one (1) reinstatement for terminations due to non-payment (per lifetime of account).

*[(E)]5.* Reinstatement before termination—MCHCP may reinstate coverage if request is received prior to end of current coverage.

*[(F)]6.* Termination of dental and/or vision coverage—MCHCP may terminate dental and/or vision coverage if request is received prior to February 1 and if no claims have been made/paid for January.

*[(G)]7.* Proof of eligibility—MCHCP may approve late receipt of proof-of-eligibility documentation if MCHCP can verify that it took an unreasonable amount of time for public entity (county or state) to provide subscriber with requested documentation.

*[(H)]8.* Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage.

*[(I)]9.* Loss of coverage notice—MCHCP may approve late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.

*[(J)]10. [Lifestyle Ladder] Wellness Program participation—MCHCP may deny all appeals regarding continuation of participation in [Lifestyle Ladder] the Wellness Program due to failure of member's participation.*

*[(K)]11. Proof of open enrollment confirmation—MCHCP may approve appeals if subscriber is able to provide a confirmation sheet from open enrollment. However, such administrative appeals must be received by MCHCP on or before the last day of February.*

*[(L)]12. Substantiating evidence—MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period.*

*[(M)]13. New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, terminated Jan. 20, 2011. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**ORDER TERMINATING EMERGENCY  
AMENDMENT**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the executive director hereby terminates an emergency amendment effective January 20, 2011, as follows:

**22 CSR 10-2.075 Review and Appeals Procedure is terminated.**

A notice of emergency rulemaking containing the text of the emergency amendment was published in the *Missouri Register* on February 1, 2011 (36 MoReg 384-387).

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-2.075 Review and Appeals Procedure.** The Missouri Consolidated Health Care Plan is amending the rule purpose and all sections of this rule.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to review and appeals procedures for participation in, and coverage of services under, the Missouri Consolidated Health Care Plan.*

*PURPOSE: This rule establishes the policy of the board of trustees in regard to review and appeals procedures for participation in, and coverage of services under, the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 20, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 20, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed January 10, 2011, becomes effective January 20, 2011, and expires on June 29, 2011.*

*[(1) When any participant shall suffer any injury or sickness giving rise to claim under these rules, s/he shall have free choice of providers practicing legally in the location in which service is provided to the end that a provider/patient relationship shall be maintained. Reimbursement will be in accordance with the benefit provisions of the type of coverage chosen by the participant.*

*(2) The plan administrator, agent or claims administrator, upon receipt of a notice of request, shall furnish to the employee the forms as are usually furnished for filing proofs of loss. If the forms are not furnished within thirty (30) days after the giving of such notice, the employee shall be deemed to have complied with the requirement as to proof of loss upon submitting, within the time fixed for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which request is made.*

*(3) Written proof of claims incurred should be furnished to the claims administrator as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the claims administrator before they are paid.*

*(4) In the case of medical benefits, the claims administrator will send written notice of any amount applied toward the deductible as well as any payments made. The claims administrator may also send a request for additional information or material to support the claim, along with reasons why this information is necessary.*

*(5) All members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the health plan contractor or claims administrator applicable to the member. Appeals to the health plan contractor or claims administrator must be made in writing within one hundred eighty (180) days of receiving the denial or notice which gave rights to the appeal. Only after these procedures have been exhausted may the member appeal directly to the Missouri Consolidated Health Care Plan to review the decision of the health plan contractor or claims administrator.*

*(A) Appeals to MCHCP shall be submitted in writing within forty-five (45) days of receiving the final decision from the member's health care plan contractor or claims administrator, specifically identifying the issue to be resolved. Administrative appeals shall be submitted in writing as soon as possible following written or verbal notice of an MCHCP staff denial of the member's administrative request. All appeals and administrative appeals shall be addressed to:*

*Attn: Appeal  
Board of Trustees  
Missouri Consolidated Health Care Plan  
PO Box 104355  
Jefferson City, MO 65110*

*(B) The board may, in its discretion, choose to conduct a hearing regarding a member's appeal. If the board decides a hearing is needed to render a decision, it may utilize a hearing officer or committee to conduct a fact-finding hearing and make proposed findings of fact and conclusions of law. In such cases—*

- 1. The hearing will be scheduled by the MCHCP;*
- 2. The parties to the hearing will be the insured and the applicable health plan or MCHCP staff in self-insured situations;*
- 3. All parties shall be notified in writing of the date, time, and location of the hearing;*
- 4. All parties shall have the right to appear at the hearing and submit written or oral evidence. The appealing party shall be responsible for all copy charges incurred by MCHCP in connection with any documentation that must be obtained through the MCHCP. These fees will be reimbursed should the party prevail in his/her appeal. They may cross-examine witnesses. They need not appear and may still offer written evidence. The strict rules of evidence shall not apply;*
- 5. The party appealing to the board shall carry the burden of proof; and*
- 6. The hearing officer shall propose findings of fact and conclusions of law, along with its recommendation, to the board. Copies of the summary, findings, conclusions, and recommendations shall be sent to all parties.*

*(C) The board may, but is not required to, review the transcript of the hearing and solicit additional evidence and argument. It will review the summary of evidence and the proposed findings of fact and conclusions of law and shall then issue its final decision on the matter.*

- 1. All parties shall be given a written copy of the board's final decision.*
- 2. All parties shall be notified that if they feel aggrieved by the final decision, they shall have the right to seek judicial review of the decision as provided by Missouri law.*

*(D) Administrative decisions made solely by MCHCP may be appealed directly to the board of trustees, by either a member or health plan contractor providing a fully-insured product.*

- 1. All the provisions of this rule, where applicable, shall apply to these appeals.*
- 2. The parties to such appeal shall be the appellant and the MCHCP shall be respondent.*
- 3. The appellant, if aggrieved by the final decision of the board, shall have the right of appeal as stated in subsection (5)(C) herein.]*

#### **(1) Claims Submissions and Initial Benefit Determinations.**

*(A) Members shall use the claims and administration procedures established by the vendor administering the particular service for which coverage, authorization, or payment is sought.*

*(B) Medical and pharmacy service claims are divided into three (3) types: pre-service, post-service, and concurrent claims.*

*1. Pre-service claims are requests for approval that the plan or vendor requires a member to obtain before getting medical care or filling a prescription, such as prior authorization or a decision whether a treatment, procedure, or medication is medically necessary.*

*A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than fifteen (15) days from the date the vendor receives the claim. The vendor may extend the time period up to an additional fifteen (15) days if, for reasons beyond the vendor's control, the decision cannot be made within the first fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.*

*B. Urgent care claims are a special type of pre-service claim that require a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within seventy-two (72) hours. Written confirmation of the decision will be sent by the vendor as soon as possible thereafter.*

*2. Post-service claims are all other claims for services including claims after medical or pharmacy services have been provided, such as requests for reimbursement or payment of the costs for the services provided.*

*A. Post-service claims must be decided within a reasonable period of time, but not later than thirty (30) days after the vendor receives the claim. If, because of reasons beyond the vendor's control, more time is needed to review the claim, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.*

*3. Concurrent claims are claims related to an ongoing course of previously-approved treatment. If the plan or vendor has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. The plan or vendor will notify a member in writing prior to reducing or ending a previously-approved course of treatment in sufficient time to allow the member or the member's provider to appeal and obtain a determination before the benefit is reduced or terminated.*

*(C) Claims incurred should be furnished to the vendor by the provider or the member as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the vendor before they are paid.*

*(D) If a member, or a provider or authorized representative on behalf of a member, submits a request for coverage or a claim for services that is denied in whole or in part, the member will receive an initial denial notice within the time frames described in this rule that will include the following information:*

- 1. The reasons for the denial;*
- 2. Reference to the plan provision, regulation, statute, clinical criteria, or guideline on which the denial was based with*

information as to how the member can obtain a copy of the provision, regulation, statute, clinical criteria, or guideline free of charge;

3. A description of any documentation or information that is necessary for the member to provide if documentation or information is missing and an explanation as to why the documentation or information is needed, if applicable; and

4. Information as to steps the member can take to submit an appeal of the denial.

**(2) General Appeal Provisions.**

(A) All individuals seeking review or appeal of a decision of the plan, plan administrator, claims administrator, or any vendor shall follow the procedures applicable to the type of decision appealed as set forth in this rule.

(B) All appeals must be submitted in writing to the appropriate reviewer as established in this rule by the member, the individual seeking review, or his/her authorized representative.

(C) Unless specifically provided otherwise in this rule, all appeals to the plan, plan administrator, claims administrator, or applicable vendor must be made, initiated in writing, within one hundred eighty (180) days of receiving the denial or notice which gave rights to the appeal.

**(3) Appeal Process for Medical and Pharmacy Determinations.**

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply.

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage once an individual has been covered under the plan, unless the individual, or a person seeking coverage on behalf of the individual, performs an act, practice, or omission that constitutes fraud, or unless such individual or person makes an intentional misrepresentation of material fact in connection with seeking coverage or any benefits under the plan.

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination.

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative.

4. External review. External review means a review of an adverse benefit determination (including a final internal adverse benefit determination) by the Missouri Department of Insurance, Financial Institutions and Professional Registration, Division of Consumer Affairs (DIFP) regarding covered medical and pharmacy benefits administered by plan vendors, UMR, Mercy Health Plans, or Express Scripts Inc., in accordance with state law and regulations promulgated by DIFP and made applicable

to the plan by agreement and between the plan and DIFP pursuant to Technical Guidance from the U.S. Department of Health and Human Services dated September 23, 2010.

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law.

6. Final external review decision. A final external review decision means a determination rendered under the DIFP external review process at the conclusion of an external review.

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect;

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

C. The termination or discontinuance of coverage is effective retroactively at the request of the member in accordance with applicable provisions of this chapter regarding voluntary cancellation of coverage.

**(B) Internal Appeals.**

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review by DIFP.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim

decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level appeals shall be responded to in writing to the member within sixty (60) days for post-service claims and within thirty (30) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First level appeals must be submitted in writing to—

UMR Claims Appeal Unit  
PO Box 30546  
Salt Lake City, UT 84130-0546

(b) Second level appeals must be sent in writing to—

UMR Claims Appeal Unit  
PO Box 8086  
Wausau, WI 54402-8086

(c) Expedited appeals must be communicated by calling UMR telephone 1-866-868-7758 or by submitting a written fax to 1-866-912-8464, Attention: Appeals Unit.

(VI) For members with medical coverage through Mercy Health Plans—

(a) First and second level appeals must be submitted in writing to—

Mercy Health Plans  
Attn: Corporate Appeals  
14528 S. Outer 40 Road, Suite 300  
Chesterfield, MO 63017

(b) Expedited appeals must be communicated by calling Mercy Health Plans telephone 1-800-830-1918, ext. 2394 or by submitting a written fax to 1-314-214-3233, Attention: Corporate Appeals.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member claimant attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the claimant believes the claim should be paid, and any other written documentation to support the claimant's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts  
Clinical Appeals—MH3  
6625 West 78th Street, BL0390  
Bloomington, MN 55439  
or by fax to 1-877-852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(4) Except as otherwise expressly provided in this rule, appeals of adverse determinations made by MCHCP may be appealed to the board by fax or letter to the following address:

Attn: Appeal  
Board of Trustees  
Missouri Consolidated Health Care Plan  
PO Box 104355  
Jefferson City, MO 65110

[(6)](5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines:/.

(A) Newborns—If a member currently has coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within three (3) months of the child's date of birth.

(B) Agency error—MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office, the MCHCP, or plan offered by MCHCP that was no fault of the member.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year.

(D) Non-payment—MCHCP may allow one (1) reinstatement for terminations due to non-payment (per lifetime of account).

(E) Reinstatement before termination—MCHCP may reinstate coverage if request is received prior to end of current coverage.

(F) Termination dental and/or vision coverage—MCHCP may terminate dental and/or vision coverage if request is received prior to February 1 and if no claims have been made/paid for January.

(G) Proof of eligibility—MCHCP may approve late receipt of proof-of-eligibility documentation if MCHCP can verify that it took an unreasonable amount of time for the public entity (county or state) to provide subscriber with requested documentation.

(H) Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage.

(I) Loss of coverage notice—MCHCP may approve late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.

(J) *[Lifestyle Ladder] Wellness Program* participation—MCHCP may deny all appeals regarding continuation of participation in *[Lifestyle Ladder] the Wellness Program* due to failure of member's participation.

(K) Proof of open enrollment confirmation—MCHCP may approve appeals if subscriber is able to provide a confirmation sheet from open enrollment. However, such administrative appeals must be received by MCHCP on or before the last day of February.

(L) Substantiating evidence—MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period.

(M) New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, terminated Jan. 20, 2011. Emergency amendment filed Jan. 10, 2011, effective Jan. 20, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

## **Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN**

### **Division 10—Health Care Plan Chapter 2—State Membership**

#### **EMERGENCY AMENDMENT**

**22 CSR 10-2.090 Pharmacy Benefit Summary.** The Missouri Consolidated Health Care Plan is amending the rule purpose and sections (1), (6), and (7); deleting section (3) and renumbering accordingly; and adding sections (7) and (8).

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for the PPO 300, PPO 600, and Medicare Supplement Plans of the Missouri Consolidated Health Care Plan.*

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for the [HMO, Copay,] PPO 300, PPO 600, and Medicare Supplement Plans of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect mem-*

*bers (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) The pharmacy benefit provides coverage for prescription drugs **listed on the formulary**, as described in the following:

(A) Medications.

1. **Retail—Network:**

A. Generic: Eight-dollar (\$8) copayment for up to a thirty (30)-day supply for generic drug on the formulary;

B. *[Formulary brand] Brand:* Thirty-five-dollar (\$35) copayment for up to a thirty (30)-day supply for brand drug on the formulary;

*[C. Non-formulary: Fifty-five dollar (\$55) copayment for up to a thirty (30)-day supply for non-formulary drug;*

*D. Prescriptions filled with a formulary brand drug when there is a Food and Drug Administration (FDA)-approved generic will be subject to the generic copayment amount in addition to paying the difference between the cost of the generic and the formulary brand drug;]*

*[E]C. Mail order program—*

(I) Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for *[two and one-half (2 ½) regular copayments] a twenty-dollar (\$20) copayment for a generic drug on the formulary or a eighty-seven-dollar-and-fifty-cent (\$87.50) copayment for a brand drug on the formulary.*

(II) Specialty drugs covered only through network mail order for up to thirty (30) days. Copayments~~[:]~~—

(a) Generic: *[six] eight dollars [and sixty-seven cents (\$6.67);] (\$8) for generic drug on the formulary list; and*

*[(b) Formulary brand: twenty-nine dollars and seventeen cents (\$29.17); and*

*(c) Non-formulary: forty-five dollars and eighty-three cents (\$45.83).]*

**(b) Brand: thirty-five dollars (\$35) for brand drug on the formulary.**

2. Non-network pharmacies—If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable copayment **or coinsurance**. All such claims must be filed within twelve (12) months of the incurred expense.

3. Retail prescription drugs—Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.



[(3)] *Retail and mail order coverage includes the following (except for specialty drugs):*

(A) *Diabetic supplies, including—*

1. *Insulin;*
2. *Syringes;*
3. *Test strips;*
4. *Lancets; and*
5. *Glucometers;*

(B) *Prescribed vitamins, excluding those vitamins that may be purchased over-the-counter;*

(C) *Prescribed self-injectables;*

(D) *Oral chemotherapy agents;*

(E) *Hematopoietic stimulants;*

(F) *Growth hormones with prior authorization;*

(G) *Infertility drugs—subject to fifty percent (50%) member coinsurance; and*

(H) *Tobacco cessation prescriptions—subject to formulary restrictions and limited to five hundred dollar (\$500) annual benefit.]*

[(4)](3) **Step Therapy**—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first step drug, the physician may request a prior authorization from the pharmacy plan administrator. If the prior authorization is approved, the member is responsible for the applicable copayment which may be higher than the first step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.

(A) **First Step—**

1. Uses primarily generic drugs;
2. Lowest applicable copayment is charged; and
3. First step drugs must be used before the plan will authorize payment for second step drugs.

(B) **Second Step—**

1. This step applies if the member's treatment plan requires a different medication after attempting the first step medication;
2. Uses primarily brand-name drugs; and
3. Typically, a higher copayment amount is applicable.

[(5)](4) **Prior Authorization**—Certain medications are subject to prior authorization. Network pharmacies will notify the member if prior authorization is required. The member or the pharmacy must contact the pharmacy plan administrator before payment will be approved.

[(6)](5) **Filing of Claims**—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy plan administrator. In order to file a claim, members must—

(A) Complete the claim form; and

(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions, except diabetic supplies. If attaching a receipt or label, the receipt or label shall include/—/:

1. Pharmacy name and address;
2. Patient's name;
3. Price;
4. Date filled;
5. Drug name, strength, and national drug code (NDC);
6. Prescription number;

7. Quantity; and

8. Days' supply.

[(7)](6) **Formulary**—The formulary *[does not change during a calendar year, unless]* is updated on a semi-annual basis, or when—

(A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; or

(B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit; *[and]* or

(C) A drug is determined to have a safety issue.

(7) **Limitation**—Prescription drugs not listed on the formulary are not a covered benefit except for prescription drugs that have been grandfathered for members who have taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011. If the participant purchased a brand-name drug that is grandfathered when there is a Food and Drug Administration (FDA)-approved generic drug, the participant shall pay the generic copayment plus the difference in the brand and generic cost of the drug. Grandfathered drugs include:

(A) Alzheimer's disease drugs;

(B) Antidepressants, including selective serotonin reuptake inhibitors (SSRIs) and selective serotonin and norepinephrine reuptake inhibitors (SNRIs);

(C) Anti-epileptics;

(D) Biologics for inflammatory conditions;

(E) Cancer drugs;

(F) Hemophilia drugs (Factor VIII and IX concentrates);

(G) Hepatitis drugs;

(H) Immunosuppressants (transplant anti-rejection agents);

(I) Insulin (basal);

(J) Low molecular weight heparins;

(K) Multiple sclerosis injectable drugs;

(L) Novel psychotropics (oral products and long-active injectables);

(M) Phosphate binders;

(N) Pulmonary hypertension drugs; and

(O) Somatostatin analogs.

(8) **Under the High Deductible Health Plan (HDHP)**, pharmacy benefits are subject to the applicable medical plan deductible and coinsurance.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

## Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership

### EMERGENCY RULE

#### 22 CSR 10-2.091 Wellness Program Coverage, Provisions, and Limitations

*PURPOSE: This rule establishes the policy of the board of trustees in regards to the wellness program.*

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2011, in accordance with the new plan year. Therefore,*



*this emergency rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the Missouri Register. This emergency rule complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 20, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Eligibility—All non-Medicare primary active, retiree, terminated vested, long term disability (LTD), survivor, and Consolidated Omnibus Budget Reconciliation Act (COBRA) subscribers and their non-Medicare primary spouses enrolled in a Missouri Consolidated Health Care Plan (MCHCP) medical plan may participate in the wellness program. Each eligible member must participate separately.

(A) Members may begin participating on or after their eligibility date or during the open enrollment (OE) period.

(B) Spouses added mid-month due to marriage with a mid-month eligibility date will not be able to participate until the first of the month following their eligibility date.

(C) Members with a break in coverage within the same plan year may continue participation if they previously completed a Health Assessment (HA). Their HA will remain on record, along with any points previously accumulated.

(2) Limitations and Exclusions.

(A) Dependent children are not eligible to participate.

(B) Subscribers and/or covered spouses under the age of eighteen (18) are not eligible to participate.

(C) Members must have a Social Security number on file with MCHCP to be eligible to participate.

(D) When Medicare becomes a subscriber's primary insurance payer, the subscriber and participating spouse are no longer eligible to participate and will lose the wellness premium.

(E) When Medicare becomes a spouse's primary insurance payer, the spouse is no longer eligible to participate and will lose the wellness premium. The non-Medicare subscriber may continue to participate in the program.

(3) Participation. Members earn points through successful completion of activities as specified in the wellness program web portal through myMCHCP.

(A) The wellness program is voluntary.

(B) Members are responsible for enrolling, participating, and completing activities, as well as keeping track of their applicable deadlines and points.

(C) Each activity has different enrollment, participation, and completion criteria.

1. Some activities require use of the Internet and/or a unique email address.

2. The vendor will make all determinations regarding activity enrollment, participation, and completion.

3. The vendor will award all points upon completion of an activ-

ity.

4. Completion of activities outside of the wellness participation period may result in points being applied to the next wellness participation period.

5. Members with disabilities may request special accommodations in writing to the vendor regarding activity participation.

(D) The required HA must be completed annually before points begin accruing.

(E) Points are assigned by the vendor in the wellness participation period in which they are earned by the participating member.

(F) The wellness participation period is the time frame in which activities must be completed in order to earn the wellness premium. The wellness participation periods are as follows: October 1–December 25; January 1–March 25; April 1–June 25; and July 1–September 25.

(G) The wellness coverage period is the time frame in which members receive the wellness premium for participation. The wellness coverage periods are as follows: January 1–March 31; April 1–June 30; July 1–September 30; and October 1–December 31.

(H) MCHCP and/or the vendor may audit participation information for accuracy. Misrepresentation or fraud could lead to termination from the wellness program, loss of the wellness premium, and/or prosecution.

(4) Wellness Premium. Members qualify for the wellness premium as follows:

(A) Points are the value of activities specified and awarded by the vendor upon successful activity completion;

(B) Points are accumulated in and can be monitored by the participating member from the wellness program web portal accessed through myMCHCP;

(C) Members reaching the minimum one hundred (100)-point threshold per wellness participation period will receive the wellness premium in the future wellness coverage period.

1. Members earning over one hundred (100) points in a given wellness participation period will receive the wellness premium in the future wellness coverage period, and all points over one hundred (100) will roll forward to be applied toward meeting the one hundred (100)-point threshold during the next wellness participation period.

2. Members not earning at least one hundred (100) points in a given wellness participation period will not receive the wellness premium for the future wellness coverage period, but the points earned totaling less than one hundred (100) will roll forward to be applied toward meeting the one hundred (100)-point threshold during the next wellness participation period.

3. A maximum of four hundred (400) points per wellness participation year is possible.

4. All earned points zero out at the end of the wellness participation year; and

(D) The wellness premium will be applied to subscriber paychecks or retiree benefit checks at the beginning of each wellness coverage period.

(5) Coordination of Programs. MCHCP and its wellness vendor may utilize participation data for purposes of offering additional programs in accordance with the wellness vendor's privacy policy.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed rule covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**EMERGENCY RULE**

**22 CSR 10-2.092 Dental Benefit Summary**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the dental benefit summary for members of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rule complies with the protections extended by the **Missouri and United States Constitutions** and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Dental plan—The dental benefit provides coverage for—

- (A) Coverage A—diagnostic and preventive services;
- (B) Coverage B—basic and restorative services; and
- (C) Coverage C—major services.

(2) Procedures for Using the Dental Plan. A member may visit the dentist of his/her choice and select any dentist on a treatment-by-treatment basis. Members may go to a participating or non-participating network dentist. If a member goes to a non-participating network dentist, the dental plan will make payment directly to the member on the lesser of the dentist billed charge or the applicable maximum plan allowance.

(3) Dental benefits, deductibles, and coinsurance include:

<b>DENTAL SERVICES</b>		
<b>Coverage A – Diagnostic &amp; Preventive</b>	<b>You Pay</b>	<b>Note</b>
Examinations Prophylaxes (teeth cleaning) Fluoride Bitewing X-rays Sealants	No deductible 0% coinsurance	Dental exams, X-rays, cleanings and fluoride treatment do not apply to the individual plan maximum
<b>Coverage B – Basic &amp; Restorative</b>	<b>You Pay</b>	<b>Note</b>
Emergency Palliative Treatment Space Maintainers All Other X-rays Minor Restorative Services (fillings) Simple Extractions	\$50/person deductible* 20% coinsurance	X-rays do not apply to the individual plan maximum
<b>Coverage C – Major Services</b>	<b>You Pay</b>	<b>Note</b>
Prosthetic Device Repair All Other Oral Surgery Periodontics Endodontics Prosthodontics (bridges, dentures) Major Restorative Services (crowns, inlays, onlays)	\$50/person deductible* 50% coinsurance	12-month waiting period for Coverage C services. The waiting period is waived with proof of 12-month continuous dental coverage for major services immediately prior to the effective date of coverage in MCHCP's dental plan
<p><i>Coverage is limited to \$1,000 per person per calendar year.</i></p> <p><i>*Coinsurance amounts apply after the \$50 individual deductible is met under either Coverage B or C, or combined.</i></p>		

(4) Alternative Treatment. If alternative treatment plans are available, this dental plan will be liable for the least costly, professionally satisfactory course of treatment. This includes, but is not limited to, services such as composite resin fillings on molar teeth, in which case the benefits are based on the cost of the amalgam (silver) filling. This also includes fixed bridges, in which case the benefits will be based on the cost of a removable partial denture.

(5) Transferring Care. If participant receives care from more than one (1) dentist or service provider for the same procedure, benefits will not exceed what would have been paid for one (1) dentist for that procedure (including, but not limited to, prosthetic devices and root canal therapy).

(6) Claim Pre-Determination. If the care member needs costs less than two hundred dollars (\$200) or is emergency care, member's dentist will proceed with treatment at member's option. If the cost estimate is more than two hundred dollars (\$200) and is not emergency care, member's dentist will determine what treatment member needs and could submit a treatment plan to dental plan for a pre-determination of benefits. This estimate will enable the member to determine in advance how much of the cost will be paid by his/her dental coverage and how much s/he will be responsible for paying.

(7) Claim Filing Deadline. Member's claims must be filed by the end of the calendar year after the year in which services were rendered. The dental plan is not obligated to pay claims submitted after this period. If a claim is denied due to a participating dentist's failure to make timely submission, participant will not be liable to such dentist for the amount that would have been payable by the dental plan, provided that member advised the dentist of participant's eligibility for benefits at the time of treatment.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expires on June 29, 2011. A proposed rule covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**EMERGENCY RULE**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the vision benefit summary for members of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Vision Plan. The vision benefit provides coverage of refractive care exams, eyeglass lenses and frames, contact lenses, and corrective laser surgeries.

(2) Vision benefits and copayments include:

VISION SERVICES		
BENEFITS	NETWORK	NON-NETWORK
<b>Exams – once every 12 months</b>		
<b>Vision Exam</b>	\$10 copayment	Reimbursed up to \$36
<b>Lenses – once every 12 months – one \$25 copayment for lenses and frames when purchased together</b>		
<b>Single vision lenses (per pair)</b>	\$25 copayment	Reimbursed up to \$28
<b>Bifocal lenses (per pair)</b>	\$25 copayment	Reimbursed up to \$45
<b>Trifocal lenses (per pair)</b>	\$25 copayment	Reimbursed up to \$56
<b>Lenticular lenses (per pair)</b>	\$25 copayment	Reimbursed up to \$80
<b>Polycarbonate lenses (per pair)</b> Applies to dependent children only	\$25 copayment	Not covered
<b>Frames – once every 24 months – one \$25 copayment for lenses and frames when purchased together</b>		
<b>Frames</b>	\$25 copayment Up to \$120 plus 20% discount on any out-of-pocket costs	Reimbursed up to \$45
<b>Contact Lenses – once every 12 months in place of eye glass lenses</b>		
<b>Elective</b> If member prefers contacts to glasses	\$10 copayment for exam Up to \$125 for contact lenses and contact lens exam (fitting and evaluation) 15% discount on the cost of contact lens exam (fitting and evaluation)	Reimbursed up to \$36 for exam Contact lenses, evaluation, design and fitting reimbursed up to \$105
<b>Necessary</b> If medically necessary with prior approval from VSP	\$10 copayment for exam Additional costs covered at 100%	Reimbursed up to \$36 for exam Contact lenses, evaluation, design and fitting reimbursed up to \$210
<b>Corrective Laser Surgery – contact your provider, or contact VSP at 888-354-4434 for more information</b>		

<b>PRK</b>	<b>Maximum amount you pay:</b> <b>\$1,500 per eye</b>	<b>Not covered</b>
<b>LASIK</b>	<b>Maximum amount you pay:</b> <b>\$1,800 per eye</b>	<b>Not covered</b>
<b>Custom LASIK</b>	<b>Maximum amount you pay:</b> <b>\$2,300 per eye</b>	<b>Not covered</b>
<b>Other</b>		
<b>Optional Items (cosmetic extras)</b>	<b>Not covered</b>	<b>Not covered</b>

(3) Value-Added Discount Program. A member can receive a twenty-percent (20%) discount on additional glasses and sunglasses, including lens options from any network provider, within twelve (12) months of participant's last eye exam.

(4) Soft Contact Lenses. A member who wears soft contact lenses will qualify for a special contact lens program. The program covers—

- (A) A contact lens exam;
- (B) Six (6)-month supply of contacts from the specific list of contact lens products and manufacturers; and
- (C) Two (2) follow-up visits.
- (D) A member who requires premium services when being fitted for contact lenses will not qualify for the contact lens care program. The member's provider will determine if the member qualifies for a standard fit or a premium fit based on the guidelines of—
  - 1. Standard fit contact lens patients—
    - A. Typically the member does not require additional time for care, training, or problem solving; and
    - B. Typically the member can be successfully fitted in up to two (2) follow-up visits; and
  - 2. Premium fit contact lens patients—
    - A. Typically the member will require additional time for care, training, or problem solving; and
    - B. Typically the member cannot be successfully fitted in up to two (2) follow-up visits.
- (E) The member will be responsible for the cost above the allowed network or non-network contact lens benefit. Contact lens care program products, manufacturers, replacement fees, and refit fees are as follows:

<b>Tier One: Spherical</b>				
<b>Product</b>	<b>Manufacturer</b>	<b>Boxes Covered</b>	<b>Replacement Wearers</b>	<b>Refit Wearers</b>
<b>ACUVUE</b>	<b>Vistakon</b>	<b>4</b>	<b>\$130</b>	<b>\$170</b>
<b>ACUVUE 2</b>	<b>Vistakon</b>	<b>4</b>		
<b>AIR OPTIX AQUA</b>	<b>CIBA Vision</b>	<b>2</b>		
<b>Biofinity</b>	<b>CooperVision</b>	<b>2</b>		
<b>Biomedics 55 Premier</b>	<b>CooperVision</b>	<b>4</b>		
<b>Biomedics 55 UV</b>	<b>CooperVision</b>	<b>4</b>		
<b>Biomedics XC</b>	<b>CooperVision</b>	<b>4</b>		
<b>Focus Monthly Visitint (Focus Visitint)</b>	<b>CIBA Vision</b>	<b>2</b>		
<b>Frequency 38</b>	<b>CooperVision</b>	<b>2</b>		
<b>Frequency 55 Aspheric</b>	<b>CooperVision</b>	<b>2</b>		
<b>Frequency 55 Sphere</b>	<b>CooperVision</b>	<b>2</b>		
<b>FreshLook Handling Tint</b>	<b>CIBA Vision</b>	<b>4</b>		
<b>O2OPTIX</b>	<b>CIBA Vision</b>	<b>2</b>		
<b>Proclear Sphere (Compatibles)</b>	<b>CooperVision</b>	<b>2</b>		
<b>PureVision</b>	<b>Bausch &amp; Lomb</b>	<b>2</b>		
<b>SofLens 39 (Optima FW, Seequence II)</b>	<b>Bausch &amp; Lomb</b>	<b>4</b>		
<b>Vertex Sphere (Encore Sphere)</b>	<b>CooperVision</b>	<b>4</b>		

<b>Tier Two: Spherical</b>				
<b>Product</b>	<b>Manufacturer</b>	<b>Initial Supply Boxes</b>	<b>Replacement Wearers</b>	<b>Refit Wearers</b>
<b>ACUVUE ADVANCE</b>	<b>Vistakon</b>	<b>4</b>	<b>\$160</b>	<b>\$190</b>
<b>ACUVUE OASYS with HYDRACLEAR PLUS</b>	<b>Vistakon</b>	<b>4</b>		
<b>AIR OPTIX NIGHT &amp; DAY AQUA</b>	<b>CIBA Vision</b>	<b>2</b>		
<b>Avaira</b>	<b>CooperVision</b>	<b>4</b>		
<b>Biomedics 38</b>	<b>CooperVision</b>	<b>4</b>		
<b>Extreme H<sub>2</sub>O 59% - Thin</b>	<b>Hydrogel</b>	<b>4</b>		
<b>Extreme H<sub>2</sub>O 59% - Xtra</b>	<b>Hydrogel</b>	<b>4</b>		
<b>Extreme H<sub>2</sub>O 54%</b>	<b>Hydrogel</b>	<b>4</b>		
<b>Focus 1-2 Week Visitint (NewVues Visitint)</b>	<b>CIBA Vision</b>	<b>4</b>		
<b>PRECISION UV</b>	<b>CIBA Vision</b>	<b>4</b>		

Tier Three: Specialty Lenses				
Product	Manufacturer	Initial Supply Boxes	Replacement Wearers	Refit Wearers
<b>ACUVUE ADVANCE <i>for ASTIGMATISM</i></b>	<b>Vistakon</b>	<b>4</b>	<b>\$180</b>	<b>\$210</b>
<b>ACUVUE OASYS <i>for ASTIGMATISM</i></b>	<b>Vistakon</b>	<b>4</b>		
<b>AIR OPTIX <i>for ASTIGMATISM</i></b>	<b>CIBA Vision</b>	<b>2</b>		
<b>Biofinity Toric</b>	<b>CooperVision</b>	<b>2</b>		
<b>Focus Monthly Toric Visitint (Focus Toric)</b>	<b>CIBA Vision</b>	<b>2</b>		
<b>Frequency 55 Multifocal</b>	<b>CooperVision</b>	<b>2</b>		
<b>Frequency 55 Toric</b>	<b>CooperVision</b>	<b>2</b>		
<b>Proclear EP Multifocal</b>	<b>CooperVision</b>	<b>4</b>		
<b>PureVision Multifocal</b>	<b>Bausch &amp; Lomb</b>	<b>2</b>		
<b>PureVision Toric</b>	<b>Bausch &amp; Lomb</b>	<b>2</b>		
<b>SofLens Toric</b>	<b>Bausch &amp; Lomb</b>	<b>4</b>		

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed rule covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership  
EMERGENCY AMENDMENT**

**22 CSR 10-3.010 Definitions.** The Missouri Consolidated Health Care Plan is deleting sections (3), (26), (33), (37), (44), (49), (53), (54), (68), (70), (77), (91)–(93), (95), (98), (114), (124), and (128); amending sections (5), (7), (10), (13), (17), (22)–(24), (29), (30), (32), (34), (36), (39), (41)–(43), (46), (48), (52), (64), (69), (71), (72), (74), (78), (81), (82), (84), (85)–(88), (90), (94), (96), (99), (101), (103)–(105), (109), (111), (113), (115), (116), (121), (126), and (131); adding new sections (2), (7), (8), (14), (15), (29), (31), (33), (40), (41), (44), (52), (55), (68), (69), (72), (95), (125), and (130); and renumbering as necessary.

*PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan relative to public entities and public entity members.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January*

*1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

*PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.*

**(2) Activities of daily living.** Bathing, dressing, toileting, and associated personal hygiene; transferring (being moved in and out of a bed, chair, wheelchair, tub, or shower); mobility, eating (getting nourishment into the body by any means other than intravenous), and continence (voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

*[(2)](3) Administrative appeal.* A written request submitted by or on behalf of a member involving plan-related administrative issues such as eligibility, effective dates of coverage, plan changes, etc.

*[(3) Administrative guidelines.* Instructive interpretation of the plan document developed for administration of the plan. The administrative guidelines may be changed upon approval of the executive director or his/her designee. Benefits provided shall be those in effect at the time services are rendered.]

**(5) Allowable expense.** Charges for services rendered or supplies furnished by a health plan that would qualify as covered expenses and for which the program pays in whole or in part, subject to any



deductible[, and coinsurance[, or table of allowance included in the program] amounts.

**(7) Applied behavior analysis.** The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior.

**(8) Assignment.** When a doctor agrees to accept Medicare's fee as full payment.

**[(7)](9) Benefit period.** The three hundred sixty-five (365) days immediately *[following the first date of like services]* after the first date of the services to treat a given condition.

**[(8)](10) Benefits.** Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator.

**[(9)](11) Birthday rule.** If both parents have medical coverage, the primary plan for dependent children is the plan of the parent whose birthday occurs first in the calendar year. If birthdays occur on the same day, the parent's coverage that has been in effect longest is primary.

**[(10)](12) Board.** The board of trustees of the Missouri Consolidated Health Care Plan (MCHCP).

**[(11)](13) Calendar year.** The period of time from January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All annual deductibles and benefit maximums accumulate during the calendar year.

**(14) Cancellation of coverage.** The voluntary cancellation of medical, dental, or vision coverage per a subscriber's request.

**(15) Case management.** A coordinated set of activities conducted for individual patient management of serious or complicated health conditions.

**[(12)](16) Chiropractic services.** The examination, diagnosis, adjustment, manipulation, and treatment of malpositioned articulations and structures of the body, directed toward restoring and maintaining the normal neuromuscular and musculoskeletal function and health.

**[(13)](17) Claims administrator.** An organization or group responsible for the processing of claims and associated services for *[the plan's self-insured benefit programs, including but not limited to the preferred provider organization (PPO) (also known as the copay plan) and health maintenance organization (HMO) type plans]* a health plan.

**[(14)](18) Coinsurance.** The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.

**[(15)](19) Comprehensive major medical.** A plan that provides for cost sharing to be applied to all covered expenses, such as deductible or coinsurance.

**[(16)](20) Congenital defect.** Existing or dating from birth. Acquired through development while in the uterus.

**[(17)](21) Convenient care clinics (CCCs).** Health care clinics located in retail stores, supermarkets, and pharmacies that treat routine family illnesses and provide preventive health care services. They are sometimes referred to as "retail-based clinics" or "walk-in medical clinics." *[CCCs are usually staffed by nurse practitioners or*

*physician assistants. Some CCCs, however, are staffed by physicians.]*

**[(18)](22) Coordination of benefits.** Communication, adjustment, and reconciliation procedures between multiple benefit plans covering the same member for purposes of covering services and expenses relating to plan benefits.

**[(19) Copay plan.** A set of benefits similar to a health maintenance organization option.]

**[(20)](23) Copayment.** A set dollar amount that the covered individual must pay for specific services.

**[(21)](24) Cosmetic surgery.** A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than restore the anatomy and/or function of the body which are lost or impaired due to illness or injury.

**[(22)](25) Covered benefits and charges.** *[A schedule of covered services and charges payable under the plan. The benefits covered under each type of plan are outlined in the applicable rule in this chapter.]* Covered benefits are a schedule of health care services payable under the plan. Covered charges are the cost for medical services eligible for consideration under the plan.

**[(23)](26) Custodial care.** Services and supplies furnished primarily to assist an individual to meet the activities of daily living<sup>1</sup>. *Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services]* that can be provided by persons without the training of a health care provider or that do not entail and require the continuing attention of trained medical or paramedical personnel.

**[(24)](27) Date of service.** Date medical services are received *[or performed]*.

**[(25)](28) Deductible.** The amount of expense the member must pay before the plan begins to pay for covered services and supplies. This amount is not reimbursable by the plan.

**[(26) Dependent-only participation.** Participation of certain survivors of subscribers. Dependent participation may be further defined to include the deceased subscriber's:

- (A) Spouse only;
- (B) Child(ren) only; or
- (C) Spouse and child(ren).]

**(29) Dependent child.** Any child under the age of twenty-six (26) that is a natural child, legally adopted or placed for adoption child, or a child with one (1) of the following legal relationships with the member, so long as such legal relationship remains in effect:

- (A) Stepchild;
- (B) Foster child for whom the employee is responsible for health care;
- (C) Grandchild for whom the employee has legal guardianship or legal custody and is responsible for providing health care; and
- (D) Other child for whom the employee is court-ordered legal guardian responsible for providing health care.

1. Except for a disabled child as described in 22 CSR 10-2.010(88), a dependent child is eligible from his/her eligibility date to the end of the month he/she attains age twenty-six (26) (see paragraph 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child beyond age twenty-six (26)).

**[(27)](30) Dependents.** The lawful spouse of the employee, the employee's unemancipated child(ren), and certain survivors of employees, as provided in the plan document and these rules, for

whom application has been made and has been accepted for participation in the plan.

**(31) Diagnostic.** Describes a procedure to determine whether a person has a particular illness.

*[(28)](32)* Diagnostic charges. The Usual, Customary, and Reasonable (UCR) charges or the network discounted rate (NDR) for x-ray or laboratory examinations made or ordered by a physician in order to detect a medical condition.

**(33) Disease management.** A program offered to non-Medicare members to help manage certain chronic diseases.

*[(29)](34)* Disposable supplies. *[Medical s/Supplies* that do not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.

*[(30)](35)* Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:

- (A) Doctor of medicine;
- (B) Doctor of osteopathy;
- (C) Podiatrist;
- (D) Optometrist;
- (E) Chiropractor;
- (F) Psychiatrist;
- [(F)](G)* Psychologist;
- [(G)](H)* Doctor of dental medicine, including dental surgery;

*[or]*

**(I) Doctor of dentistry; or**

*[(H)](J)* Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

*[(31)](36)* Durable medical equipment (DME). Equipment able to withstand repeated use for the therapeutic treatment of an active illness or injury. Such equipment is not covered under the plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.

*[(32)](37)* Eligibility date. *[Refer to]As described in 22 CSR 10-3.020. [for effective date provisions. Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of eligibility as determined by the employer.]*

*[(33)* Emancipated child(ren). A child(ren) who is—

- (A) Employed on a full-time basis;
- (B) Eligible for group health benefits in his/her own behalf;
- (C) Maintaining a residence separate from his/her parents or guardian—except for full-time students in an accredited school or institution of higher learning; or
- (D) Married.]

*[(34)](38)* Emergency medical condition. *[Any medical condition leading a prudent layperson to seek immediate medical attention. This normally means the sudden onset of a health condition that manifests itself by acute symptoms and severity (including severe pain). Examples of medical emergencies include, but are not limited to:] A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—*

- (A) Conditions placing a person's health in significant jeopardy;
- (B) Serious impairment to a bodily function;
- (C) Serious dysfunction of any bodily organ or part;

(D) Inadequately controlled pain; or

(E) Situations when the health of a pregnant woman or her unborn child are threatened.

*[(35)](39)* Emergency room. The section of a hospital equipped to furnish emergency care to prevent the death or serious impairment of the covered person.

**(40) Emergency Services.** With respect to an emergency medical condition—

(A) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the patient. The term “to stabilize” means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility.

**(41) Employee.** A person employed by a participating public entity and present and future retirees from the participating public entity who meet the eligibility requirements as prescribed by the participating public entity.

*[(36)](42)* Employee and dependent participation. Participation of an employee and the employee's eligible dependents. Any individual eligible for participation as an employee is not eligible as a dependent except as noted in 22 CSR 10-3.030(1)(A)7. *[Dependent participation may be further defined to include the participating employee's:*

- (A) Spouse only;
- (B) Child(ren) only; or
- (C) Spouse and child(ren).]

*[(37)* Employees. Employees of the participating public entity and present and future retirees from the participating public entity who meet the eligibility requirements as prescribed by the participating public entity.]

*[(38)](43)* Employer. The public entity that employs the eligible employee as defined above.

**(44) Essential benefits.** The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

(A) Ambulatory patient services—office visits, urgent care, outpatient diagnostic procedures, outpatient surgery, and outpatient hospice;

(B) Emergency services—ambulance services and emergency room services;

(C) Hospitalization—inpatient hospital benefits, inpatient surgery, transplants, and inpatient hospice;

(D) Maternity and newborn care—maternity coverage and newborn screenings;

(E) Mental health and substance abuse disorder services, including behavioral health treatment—inpatient and outpatient and mental health/chemical dependency office visits;

(F) Prescription drugs;

(G) Rehabilitative and habilitative services and devices—durable medical equipment; cardiac and pulmonary rehabilitation; outpatient physical, speech, and occupational therapy; and home health care/palliative services;

(H) Laboratory services—lab and x-ray;

(I) Preventive and wellness services and chronic disease management; and

(J) Pediatric services, including oral and vision care—routine

**vision exam, dental care/accidental injury, immunizations, preventive services, and newborn screenings.**

**[(39)](45)** Executive director. The chief executive officer of the Missouri Consolidated Health Care Plan (MCHCP) who shall have charge of the offices, records, and employees of the plan, subject to the direction of the board of trustees.

**[(40)](46)** Experimental/Investigational/Unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below is considered experimental/investigational/unproven and is not eligible for coverage under the plan. Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community. Experimental/investigational/unproven is defined as a treatment, procedure, device, or drug that the plan administrator determines, in the exercise of its discretion, is—

(A) Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law;

(B) Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or

(C) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficiency as compared with the standard means of treatment or diagnosis.

**[(41)](47)** First eligible. The first thirty-one (31)-day period after a member's employment date in which the member and his/her dependents may enroll in an MCHCP plan. As a member acquires new dependents, his/her first eligible period is the first thirty-one (31) days from the date *[the dependent meets the eligibility requirements for coverage under the plan]* of the lift event.

**[(42)](48)** Formulary. A list of drugs covered by the pharmacy *[program claims administrator]* benefit manager and as allowed by the plan administrator.

**[(43)](49)** Generic drug. *[A chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.]* There are two (2) types of generic drugs, a therapeutically equivalent generic and a chemically equivalent generic, as defined below.

(A) Therapeutically equivalent generic drugs are drugs with active ingredients that are similar at the clinical level.

(B) Chemically equivalent generic drugs are drugs with active ingredients that are identical at the molecular level. The brand-name drug lost its patent and the generic is available for the exact drug.

**[(44)]** Grievance. A written complaint submitted by or on behalf of a member regarding either:

(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or

(B) Claims payment, handling, or reimbursement for health care services.]

**[(45)](50)** Group health plan. A plan maintained by an employer or an employee organization to provide medical care or other health services, directly or indirectly, to employees, former employees, and their families, including but not limited to Medicare and Medicaid plans.

**[(46)](51)** Handbook. The summary plan document prepared for members explaining the terms, conditions, and all material aspects of the plan and benefits offered under the plan, a copy of which is incorporated by reference into this rule. The full text of material incorporated by reference *[will be made]* is available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, 2010 State Member Handbook *[(January 1, 2010)]* **January 10, 2011** or online at [www.mchcp.org](http://www.mchcp.org). It does not include any later amendments or additions.

**(52) Health care benefit. Coverage under the plan to include medical, dental, vision, and pharmacy.**

**[(47)](53)** Health savings account (HSA). A tax-advantaged savings account that may be used to pay current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA. HSA funds can be used to help pay the deductible, coinsurance, and any qualified medical expenses not covered by the health plan.

**[(48)](54)** High Deductible Health Plan (HDHP). A health plan with higher deductibles than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

**[(49)]** Home health agency. An agency certified by Medicare and the Missouri Department of Health and Senior Services, or any other state's licensing or certifying body, to provide health care services to persons in their homes.]

**(55) Home health care. Skilled nursing services and other therapeutic services to persons in their homes provided by an agency certified by Medicare and licensed pursuant to state or local law.**

**[(50)](56)** Hospice. A public agency, private organization, or a subdivision of either, that primarily engages in providing care to terminally ill individuals, meets the conditions of participation for hospices, holds a valid Medicare provider agreement, and is licensed pursuant to state law.

**[(51)](57)** Hospice facility. A public or private organization, certified by Medicare and any other state's licensing or certifying body, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one (1) physician, one (1) registered nurse, one (1) social worker, one (1) volunteer, and a volunteer program. A hospice facility is not a facility, or part thereof, which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.

**[(52)](58)** Hospital.

(A) An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic, and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24)-hour-a-day nursing service by a registered nurse (RN) on duty or call.

(B) An institution not meeting all the requirements of **[(52)(A)]** subsection **(58)(A)** above, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

(C) An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).

(D) A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.

(E) A residential alcoholism, chemical dependency, or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction.

(F) In no event shall the term hospital include a skilled nursing facility or any institution, or part thereof, which is used primarily as a skilled nursing facility, nursing home, rest home, or facility for the aged.

*[(53) Hospital copayment. Set dollar amount a subscriber must pay for each hospital admission.]*

*[(54) Hospital room charges. The hospital's most common charge for semi-private accommodations, or the most common charge for a private room if that is the only type of room available or if a private room has been recommended by a physician and approved by the claims administrator or the plan administrator.]*

*[(55)](59) Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered as any other illness.*

*[(56)](60) Incident. A definite and separate occurrence of a condition.*

*[(57)](61) Infertility. Any medical condition causing the inability or diminished ability to reproduce.*

*[(58)](62) Infertility services. Services including confinement, treatment, or other services related to the restoration of fertility or the promotion of conception.*

*[(59)](63) Injury. A condition that results independently of an illness and all other causes and is a result of an external force or accident.*

*[(60)](64) Inpatient. Confined to a registered bed. Patient in hospital, skilled nursing facility, hospice facility, or free-standing chemical dependency treatment center.*

*[(61) Legend. Any drug that requires a prescription from either a physician or a practitioner, under either federal or applicable state law, in order to be dispensed.]*

*[(62)](65) Life events. Events occurring in an individual's life to include: marriage, birth, adoption, or placement of children.*

*[(63)](66) Lifetime. The period of time a member or the member's eligible dependents participate in the plan.*

*[(64)](67) Lifetime maximum. The [maximum] amount payable by a medical plan during a covered member's life for specific non-essential benefits.*

**(68) MCHCPid. An individual MCHCP member identifier used for member verification and validation.**

**(69) myMCHCP. A secure MCHCP member website that includes coverage selection, level of coverage, an option to change a mailing address, an option to add or change an email address, an option to request an MCHCPid card, and access to other pertinent websites.**

*[(65)](70) Medical benefits coverage. Services that are received from providers recognized by the plan and are covered benefits under the plan.*

*[(66)](71) Medically necessary. Treatments, procedures, services, or*

supplies that the plan administrator determines, in the exercise of its discretion[:]-

(A) Are expected to be of clear clinical benefit to the patient;

(B) Are appropriate for the care and treatment of the injury or illness in question; and

(C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.

**(72) Medicare allowed amount. The fee Medicare sets as reasonable for a covered medical service. This is the amount a provider is paid by the member and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or provider.**

*[(67)](73) Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.*

*[(68) Morbid obesity. Body Mass Index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions approved by the plan administrator based on clinical review.]*

*[(69)](74) Network provider. A physician, hospital, pharmacy, [etc.,] or other health provider that is contracted with the plan or its designee.*

*[(70) Non-embedded deductible. The family deductible that must be met before claim payments begin, applicable when two (2) or more family members are covered in the HDHP.]*

*[(71)](75) Non-formulary. A drug not contained on the pharmacy [program's formulary] benefit manager's list [but may be covered under the terms and conditions of the plan] of covered drugs.*

*[(72)](76) Non-network provider or non-participating provider. Any physician, hospital, pharmacy, [etc.,] or other health provider that does not have a contract with the plan or its designee.*

*[(73)](77) Nurse. A registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule.*

*[(74)](78) Nursing home. An institution operated, pursuant to law, primarily for custodial care or for patients [convalescing] recovering from illness or injury, under the supervision of a physician or registered nurse and having twenty-four (24)-hour nursing care. Also, an institution meeting the preceding criteria which is established for the treatment of sick and injured persons through spiritual means and is operated under the authority of organizations [which] that are recognized under Medicare.*

*[(75)](79) Open enrollment period. A period designated by the plan during which subscribers may enroll, switch, or change their level of*

coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year.

[(76)](80) Out-of-area. Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria.

[(77)] Out-of-network. *Providers that do not participate in the member's health or pharmacy plan.*

[(78)](81) Out-of-pocket maximum. *[The maximum amount the member must pay before the plan begins paying one hundred percent (100%) of covered charges for the remainder of the calendar year.] The annual limit on the amount a member must pay for covered services. Above this limit, the medical plan pays one hundred percent (100%) for covered services for the rest of the plan year.*

[(79)](82) Outpatient. Treatment either outside a hospital setting or at a hospital when room and board charges are not incurred.

[(80)](83) Outpatient observation stay. Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services are less than twenty-four (24) hours. Members may receive observation services in the emergency room, an observation unit, the intensive care unit, or a regular floor.

[(81)](84) Palliative services. Care provided by a team approach that improves the quality of life for patients and their families facing problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and *[impeccable]* assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

[(82)](85) Partial hospitalization. A distinct and organized intensive ambulatory treatment service, less than twenty-four (24)-hour daily care specifically designed for the diagnosis and active treatment of a mental/nervous disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.

(A) Partial hospitalization programs must provide diagnostic services; services of social workers; *[psychiatric]* nurses and staff trained to work with psychiatric patients; individual, group, and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions *[for therapeutic purposes]*.

(B) The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a physician.

[(83)](86) Participant. Any employee or dependent accepted for membership in the plan.

[(84)](87) Pharmacy benefit manager (PBM). *[Acts as a link between the parties involved in the delivery of prescription drugs to health plan members.]* The PBM designs, implements, and manages the overall drug benefit of the plan and processes claims payments.

[(85)](88) Physically or mentally disabled. *[The inability of a person]* A person's **inability** to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition.

[(86)](89) Physician/Doctor. A licensed practitioner of the healing arts, acting within the scope of his/her practice, as licensed under section 334.021, RSMo.

[(87)](90) Plan. The program of health care benefits established by the **board of** trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

[(88)](91) Plan administrator. The **board of** trustees of the Missouri Consolidated Health Care Plan. *As such, the board*, which is the sole fiduciary of the plan~~],~~ **The board** has all discretionary authority to interpret its provisions and to control the operation and administration of the plan~~],~~ and whose decisions are final and binding on all parties.

[(89)](92) Plan document. The statement of the terms and conditions of the plan as promulgated by the plan administrator in this chapter.

[(90)](93) Plan year. *[Same as]* The calendar year **beginning January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All deductibles and benefit maximums accumulate during the calendar year.**

[(91)] *Pre-admission testing. X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission.*

[(92)] *Pre-certification. Also known as pre-admission certification, pre-admission review, and pre-certification. The process of obtaining certification or authorization from the plan for routine hospital admissions and surgical or diagnostic procedures (inpatient or outpatient).]*

[(93)] *Pre-existing condition. A condition for which a member has incurred medical expenses or received treatment prior to the effective date of coverage.]*

(94) Preferred provider organization (PPO). An arrangement with providers whereby discounted rates are given to **plan** members. *[of the plan who, in turn, are offered a financial incentive to use these providers]* **Benefits are paid at a higher level when network providers are used.**

[(95)] *Prevailing fee. The fee charged by the majority of dentists.]*

(95) Preventive service. **A procedure intended for avoidance or early detection of an illness.**

(96) Primary care physician (PCP). A physician (usually an internist, family/general practitioner, or pediatrician) who has contracted with *[and been approved by]* a medical plan.

(97) Prior authorization. A cost control procedure that requires the service or medication to be approved in advance by the doctor and/or the plan. Without prior authorization, the plan may not pay for the test, drug, or service. Also known as pre-authorization or pre-notification.

[(98)] *Prior plan. The terms and conditions of a plan in effect for the period preceding coverage in the plan.]*

[(99)](98) Private duty nursing. *[Private duty nursing services, n]* Nursing care on a full-time basis in the member's home~~],~~ or home health aides.

**[(100)/(99)]** Proof of eligibility. Documentation required by the plan to determine a dependent's qualification for health insurance coverage.

**[(101)/(100)]** Proof of **prior group** insurance. Evidence in written form from an insurance company that provides verification of coverage for a given period of time.

**[(102)/(101)]** Proof of prior coverage. If a member or his/her dependents enroll in an MCHCP plan due to loss of coverage, the member must provide proof of prior group coverage. This includes a letter from the previous insurance carrier or former employer which states all the following:

- (A) Date coverage was or will be terminated;
- (B) Reason for coverage termination; and
- (C) List of dependents covered.

**[(103)/(102)]** Prostheses. An artificial extension that replaces a missing part of the body/. *Prostheses are typically used to replace parts lost by injury (traumatic) or missing from birth (congenital)* or *[to]* supplements defective parts.

**[(104)/(103)]** Protected health information (PHI). Any information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. This information also relates to the past, present, or future physical or mental health or condition of the individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual.

**[(105)/(104)]** Provider. *[Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.]* A **physician, hospital, medical agency, specialist, or other duly-licensed health care facility or practitioner** certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-3.010(35). Other providers include but are not limited to:

- (A) Audiologist (AUD or PhD);
- (B) Certified Addiction Counselor for Substance Abuse (CAC);
- (C) Certified Nurse Midwife (CNM)—when acting within the scope of their license in the state in which they practice and performing a service which would be payable under this plan when performed by a physician;
- (D) Certified Social Worker or Masters in Social Work (MSW);
- (E) Licensed Clinical Social Worker;
- (F) Licensed Professional Counselor (LPC);
- (G) Licensed Psychologist (LP);
- (H) Nurse Practitioner (NP);
- (I) Physicians Assistant (PA);
- (J) Qualified Occupational Therapist;
- (K) Qualified Physical Therapist;
- (L) Qualified Speech Therapist;
- (M) Registered Nurse Anesthetist (CRNA);
- (N) Registered Nurse Practitioner (ARNP); or
- (O) Therapist with a PhD or Master's Degree in Psychiatry or related field.

**[(106)/(105)]** Provider directory. A listing of network providers within a health plan.

**[(107)/(106)]** Prudent layperson. An individual possessing an average knowledge of health and medicine.

**[(108)/(107)]** Public entity. A state-sponsored institution of higher learning, political subdivision, or governmental entity or instrumentality that has elected to join the plan and has been accepted by the board.

**[(109)/(108)]** Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or *[an enrollee]* **member** if the plan normally provides coverage for dependent children.

**[(110)/(109)]** Reconstructive surgery. A procedure performed to restore the anatomy and/or functions of the body that are lost or impaired due to an injury or illness.

**[(111)/(110)]** Refractions. A record of the patient's preference for the focusing of the eyes that *[can]* **may** then be used to purchase eyeglasses or **contact lenses**. It is the *[portion of the eye]* **part of the** exam that determines what prescription lens *[provides]* **gives** the patient *[with]* the best possible vision.

**[(112)/(111)]** Rehabilitation facility. A legally operating institution, or distinct part of an institution, that has a transfer agreement with one (1) or more hospitals and is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute hospital, and rehabilitative inpatient care, and is duly licensed by the appropriate government agency to provide such services.

(A) It does not include institutions that provide only minimal care, custodial care, ambulatory or part-time care services, or an institution that primarily provides treatment of mental/nervous disorders, substance abuse, or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission for the Accreditation of Rehabilitation Facilities.

**[(113)/(112)]** Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-3.020(6)(B) and is currently receiving a monthly retirement benefit from *[one (1) of the retirement systems listed in such rule]* a **public entity**.

**[(114)]** *Second opinion program. A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service.]*

**[(115)/(113)]** Skilled nursing care. *[Care which]* **Services that** must be performed by, or under the supervision of, licensed personnel and meets criteria as established by the claims administrator.

**[(116)/(114)]** Skilled nursing facility (SNF). *[An institution which meets fully each of the following requirements:*

*(A) It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board, and twenty-four (24)-hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;*

*(B) It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and*

*(C) A skilled nursing facility shall be deemed to include institutions meeting the criteria in this rule which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97).] A public or private facility licensed and operated according to the law that provides—*

**(A) Permanent and full-time facilities for ten (10) or more resident patients;**

**(B) A registered nurse or physician on full-time duty in charge of patient care;**

**(C) At least one (1) registered nurse or licensed practical nurse on duty at all times;**

**(D) A daily medical record for each patient;**

**(E) Transfer arrangements with a hospital; and**

**(F) A utilization review plan.**

The facility must be primarily engaged in providing continuous skilled nursing care for persons during the recovery stage of their illness or injury, and is not, other than by coincidence, a rest home for custodial care or for the aged.

**[(117)](115)** Sound natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

**[(118)](116)** Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

**[(119)](117)** Specialty medications. High cost drugs that are primarily self-injectible but sometimes oral medications.

**[(120)](118)** State. Missouri.

**[(121)](119)** Step therapy. Designed to encourage use of therapeutically-equivalent, lower-cost alternatives before *[stepping up to]* using more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

**[(122)](120)** Subrogation. The substitution of one (1) “party” for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the participant and recover the money directly from the other insurer.

**[(123)](121)** Subscriber. The employee or member who elects coverage under the plan.

**[(124) Subscriber only participation. Participation of a subscriber without participation of the subscriber’s dependents, whether or not the subscriber has dependents.]**

**[(125)](122)** Surgery. Any operative or invasive diagnostic procedure performed in the treatment of an injury or illness by an instrument or cutting procedure through any natural body opening or incision.

**[(126)](123)** Surgery center (ambulatory). A hospital-based, hospital-sponsored, or independently-owned facility that performs surgery.

**[(127)](124)** Survivor. A member who meets the requirements of subsection 22 CSR 10-3.020(6)(A).

**(125) Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.**

**[(128) Unemancipated child(ren). A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-five (25) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:**

**(A) Stepchild(ren);**

**(B) Foster child(ren) for whom the employee is responsible for health care;**

**(C) Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care; and**

**(D) Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator.**

**(E) Except for a disabled child(ren) as described in section (85) of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-five (25) (see paragraph 22 CSR 10-3.020(4)(D)2. for continuing coverage on a handicapped child(ren) beyond age twenty-five (25)); and**

**(F) Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for providing coverage is also covered as a dependent under the plan.]**

**[(129)](126)** Urgent care. Medically necessary services in order to prevent rapid and/or serious deterioration in a member’s health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician office but not severe enough to require treatment in a hospital emergency department.

**[(130)](127)** Urgent care centers. Medical facilities that provide extended or twenty-four (24)-hour service to treat minor conditions at a lower cost than emergency room treatment.

**[(131)](128)** Usual, Customary, and Reasonable *[C]charge*.

**(A) Usual—The fee a *[physician]* provider most frequently charges the majority of his/her patients for the same or similar services.**

**(B) Customary—The range of fees charged in a geographic area by *[physicians]* providers of comparable skills and qualifications for the same performance of similar service.**

**(C) Reasonable—The flexibility to take into account any unusual clinical circumstances involved in performing a particular service.**

**(D) A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the *[doctors]* providers for ninety percent (90%) of the procedures reported.**

**[(132)](129)** Utilization review. Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities on a prospective, concurrent, or retrospective basis.

**(130) Vendor. The current applicable third-party administrator of MCHCP benefits.**

[(133)](131) Vested subscriber. A member who meets the requirements of subsection 22 CSR 10-3.020(6)(B).

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-3.045 Plan Utilization Review Policy.** The Missouri Consolidated Health Care Plan is amending section (1).

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan medical plans.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program [consists of four (4) parts, as described in the following] has the following components:

(A) [Precertification—The medical necessity of a non-emergency hospital admission, specified procedures as documented in the claims administrator's guidelines, and/or skilled nursing services provided on an inpatient basis must be prior authorized by the appropriate claims administrator. For emergency hospital admissions, the claims administrator must be notified within forty-eight (48) hours of the admission. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;] Prior authorization of services—The claims administrator must authorize some services in advance. Without prior authorization, any claim that requires prior authorization will not be covered.

Participants who have another primary carrier, including Medicare, are not subject to this provision. Prior authorization does not verify eligibility or payment. Prior authorizations based on a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition will not be covered.

1. The following medical services are subject to prior authorization:

A. Ambulance services for non-emergency use whether air or ground;

B. Applied behavioral analysis for autism;

C. Cardiac and pulmonary rehabilitation after thirty-six (36) visits within a twelve (12)-week period;

D. Chiropractic services after twenty-six (26) visits annually;

E. Cochlear implant device;

F. Dental care to reduce trauma and restorative services when the result of accidental injury;

G. Durable medical equipment (DME) over one thousand five hundred dollars (\$1,500) or DME rentals over five hundred dollars (\$500) per month;

H. Genetic testing or counseling;

I. Home health care and palliative services;

J. Hospice care;

K. Hospital inpatient services except for observation stays;

L. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

M. Nutritional counseling after three (3) sessions annually;

N. Orthotics over one thousand dollars (\$1,000);

O. Oxygen provided on an outpatient basis;

P. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per incident;

Q. Prostheses over one thousand dollars (\$1,000);

R. Skilled nursing facility;

S. Surgery (outpatient)—The following outpatient surgical procedures: potential cosmetic surgery, sleep apnea surgery, implantable stimulators, surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams; surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth; reduction of fractures and dislocations of the jaw; excision of exostosis of jaws and hard palate; external incisions and drainage of cellulitis; incision of accessory sinuses, salivary glands, or ducts; or frenectomy); and

T. Transplants including requests related to covered travel and lodging.

2. The following pharmacy services are subject to prior authorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications. Drugs that treat chronic, complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis. The specialty medication requires frequent dosage adjustments, clinical monitoring, and special handling and are often unavailable at retail pharmacies. The specialty medication must be filled through the claims administrator's home delivery pharmacy provider;



C. Medications that may be prescribed for several conditions including some where treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. The cost of the medication exceeds nine thousand nine hundred ninety-nine dollars and ninety-nine cents (\$9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents (\$1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents (\$149.99) for compound medications.

**3. Prior authorization time frames.**

A. A benefit determination for non-urgent prior authorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen (15)-calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least forty-five (45) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent prior authorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

(B) Concurrent Review—The claims administrator will *[continue to]* monitor the medical necessity of the inpatient admission *[and approve]* to certify the necessity of the continued stay in the hospital. *[Retirees and other participants for whom Medicare is the primary payor]* Participants who have another primary carrier, including Medicare, are not subject to this provision; and

*[(C) Large Case Management—Members who require long-term acute care may be offered the option of receiving the care, if appropriate, in a more cost-effective setting such as a skilled nursing facility or their own home. In some cases, this may require coverage for benefits that normally are not covered under the plan. These benefits may be provided through the approval of the claims administrator;*

*(D) Hospital Bill Audits—Certain hospital bills will be subject to review to verify that the services billed were actually provided and/or the associated billed amounts are accurate and appropriate; and*

*(E) Penalties—Members not complying with subsections (1)(A) and (B) of this rule may be subject to a financial penalty in connection with their covered benefits.]*

(C) Retrospective Review—Reviews conducted after services have been provided to a patient. The retrospective review includes an evaluation of reimbursement levels, accuracy and adequacy of documentation or coding, or settling of payment.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY RESCISSION**

**22 CSR 10-3.050 Copay Plan Benefit Provisions and Covered Charges.** This rule established the policy of the board of trustees to the Copay Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule is being rescinded because it is no longer needed.*

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this rescission is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be registered immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the Missouri Register. This emergency rescission complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed December 20, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency rescission filed Dec. 20, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed rescission covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY RESCISSION**

**22 CSR 10-3.051 PPO 300 Plan Benefit Provisions and Covered Charges.** This rule established the policy of the board of trustees in regard to the PPO 300 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule is being rescinded because it is no longer needed.*

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this rescission is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not*

made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be registered immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the *Missouri Register*. This emergency rescission complies with the protections extended by the *Missouri* and *United States Constitutions* and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed December 21, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.

**AUTHORITY:** section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency rescission filed Dec. 21, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed rescission covering this same material is published in this issue of the *Missouri Register*.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY RESCISSION**

**22 CSR 10-3.052 PPO 500 Plan Benefit Provisions and Covered Charges.** This rule established the policy of the board of trustees in regard to the PPO 500 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

**PURPOSE:** This rule is being rescinded because it is no longer needed.

**EMERGENCY STATEMENT:** This emergency rescission must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this rescission is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be registered immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the *Missouri Register*. This emergency rescission complies with the protections extended by the *Missouri* and *United States Constitutions* and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed December 20, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.

**AUTHORITY:** section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010.

Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency rescission filed Dec. 20, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed rescission covering this same material is published in this issue of the *Missouri Register*.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1), (2), and (4).

**PURPOSE:** This amendment includes changes to the policy of the board of trustees in regard to the PPO 1000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

**EMERGENCY STATEMENT:** This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri* and *United States Constitutions* and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.

(1) Deductible amount—Network: per individual each calendar year, one thousand dollars (\$1,000); family limit each calendar year, three thousand dollars (\$3,000). Non-network: per individual each calendar year, two thousand dollars (\$2,000); family limit each calendar year, six thousand dollars (\$6,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) The family deductible is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member deductibles may be used to meet the family deductible. Applicable charges received by one (1) family member may only meet the individual deductible amount.

(C) During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance. The newborn will not be subject to a separate deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital.

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(D) Claims *[may also]* shall be paid at ninety percent (90%) if required covered services are not available through a network provider within *[fifty (50)]* one hundred (100) miles of the member's home. The participant must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is *[not permanent]* for three (3) months. After three (3) months, the participant must contact the claims administrator to reassess network availability.

(4) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; *[percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits;]* the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1), (2), and (4).

*PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the PPO 2000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment com-*

*plies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Deductible amount—Network: per individual each calendar year, two thousand dollars (\$2,000); family limit each calendar year, six thousand dollars (\$6,000). Non-network: per individual each calendar year, four thousand dollars (\$4,000); family limit each calendar year, twelve thousand dollars (\$12,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) The family deductible is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member deductibles may be used to meet the family deductible. Applicable charges received by one (1) family member may only meet the individual deductible amount.

(C) During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance. The newborn will not be subject to a separate deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital.

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(D) Claims *[may also]* shall be paid at eighty percent (80%) if required covered services are not available through a network provider within *[fifty (50)]* one hundred (100) miles of the member's home. The participant must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is *[not permanent]* for three (3) months. After three (3) months, the participant must contact the claims administrator to reassess network availability.

(4) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; *[percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits;]* the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-3.055 High Deductible Health Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1)–(3) and (5) and adding sections (6) and (7).

*PURPOSE:* This amendment includes changes to the policy of the board of trustees in regard to the High Deductible Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT:* This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.

(1) Deductible amount—Network: per individual each calendar year, one thousand two hundred dollars (\$1,200); family limit each calendar year, two thousand four hundred dollars (\$2,400). Non-network: per individual each calendar year, two thousand four hundred dollars (\$2,400); family limit each calendar year, four thousand eight hundred dollars (\$4,800).

(A) The family deductible must be met before claim payments begin, applicable when two (2) or more family members are covered.

(B) During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance. The newborn will not be subject to a separate deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital.

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(D) Claims [may also] shall be paid at eighty percent (80%) if required covered services are not available through network provider within [fifty (50)] one hundred (100) miles of the member's home. The participant must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is [not permanent.] for three (3) months. After three (3) months, the participant must contact the claims administrator to reassess network availability.

(E) Preventive care—network claims are paid at one hundred percent (100%). Non-network claims are paid at sixty percent (60%) coinsurance after the deductible.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; [percentage amount coinsurance is reduced as a result of non-compliance with prior authorization] the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) Pharmacy benefits are subject to the [applicable medical plan] High Deductible Health Plan (HDHP) deductible and coinsurance.

(6) A member does not qualify for the HDHP if they are covered under or enrolled in any of the following types of insurance plans or programs:

(A) Medicare;

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only and dependent care section;

(D) Health reimbursement account (HRA); or

(E) The participant has veteran's benefits that have been used within the past three (3) months.

(7) A member may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

*AUTHORITY:* section 103.059, RSMo 2000 and section 103.080.3, RSMo Supp. [2009] 2010. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the *Missouri Register*.

## Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

### EMERGENCY RULE

#### 22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges

*PURPOSE:* This rule establishes the policy of the board of trustees in regard to the PPO 600 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT:* This emergency rule must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan

year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rule complies with the protections extended by the **Missouri and United States Constitutions** and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.

(1) Deductible amount—Network: per individual each calendar year, six hundred dollars (\$600); family limit each calendar year, one thousand two hundred dollars (\$1,200). Non-network: per individual each calendar year, one thousand two hundred dollars (\$1,200); family limit each calendar year, two thousand four hundred dollars (\$2,400).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) The family deductible is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member deductibles may be used to meet the family deductible. Applicable charges received by one (1) family member may only meet the individual deductible amount.

(C) During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance. The newborn will not be subject to a separate deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if he/she is transferred to another hospital.

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims—are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims shall be paid at ninety percent (90%) if the subscriber requires covered services that are not available through a network provider within one hundred (100) miles of his/her home. The participant must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is for three (3) months. After three (3) months, the participant must contact the claims administrator to reassess network availability.

(E) Preventive care—network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network out-of-pocket maximum for individual—one thousand five hundred dollars (\$1,500).

(B) Network out-of-pocket maximum for family—three thousand dollars (\$3,000).

(C) Non-network out-of-pocket maximum for individual—three thousand dollars (\$3,000).

(D) Non-network out-of-pocket maximum for family—six thousand dollars (\$6,000).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: claims for services paid at one hundred percent (100%); charges above the usual, customary, and reasonable limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(4) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed rule covering this same material is published in this issue of the Missouri Register.*

## **Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership**

### **EMERGENCY RULE**

#### **22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the Medical Plan Benefit Provisions and Covered Charges for participation in the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the Missouri Register. This emergency rule complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Benefit Provisions Applicable to the PPO 600, PPO 1000, PPO 2000, and High Deductible Health Plan (HDHP) Plans. Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a participant while covered under the plans, provided the deductible requirement, if any, is met.

(2) Covered Charges Applicable to the PPO 600, PPO 1000, PPO 2000, and HDHP Plans.

(A) Only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a noncovered service, and which are—

1. Prescribed by a doctor or provider for the therapeutic treatment of injury or sickness;
2. To the extent they do not exceed any limitation;
3. Not excluded by the limitations; and
4. For not more than the usual, reasonable, and customary charge as determined by the claims administrator for the services provided, will be considered covered charges.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, reasonable, and customary, the claims administrator will consider the following:

1. The medical benefits or supplies usually rendered or prescribed for the condition; and
2. The usual, reasonable, and customary charges in the area in which services and/or supplies are provided.

(C) A physician visit to seek a second opinion is a covered service.

(D) Plan benefits for the PPO 600, PPO 1000, PPO 2000, and HDHP Plans are as follows:

PUBLIC ENTITY BENEFITS	
<b>Allergy Serum</b> <b>Multi-dose vial</b>	<b>No coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers or air ventilation system cleaning.</b>
<b>Ambulance Service</b> <b>Non-emergency air or ground excluded unless prior authorization received from medical plan.</b>	<b>Use of air ambulance or medical helicopter service from any continent returning to the U.S. is excluded.</b>
<b>Applied Behavioral Analysis for Autism</b> <b>For children younger than age 19</b>	<b>The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of observation, measurement and functional analysis of the relationship between environment and behavior.</b>  <b>\$40,000 annual limit. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary.</b>  <b>Prior authorization by medical plan required.</b>
<b>Birth Control Prescriptions</b>	
<b>Birth Control Devices and Injections</b> <b>Administered in the physician's office.</b>	
<b>Cardiac and Pulmonary Rehabilitation</b> <b>Up to 36 visits within a 12-week period per incident</b>	<b>Prior authorization by medical plan required after 36 visits within a 12-week period.</b>
<b>Chelation Therapy</b> <b>Limited to treatment of lead poisoning in children as recommended by Missouri Department of Health and Senior Services.</b>	
<b>Chiropractic Services</b> <b>Up to 26 visits annually</b>	<b>Prior authorization by medical plan required after 26 visits annually.</b>
<b>Cochlear Implant Device</b>	<b>Prior authorization by medical plan required.</b>
<b>Colonoscopy</b>	
<b>Convenient Care Clinic (CCC)</b>	

**Dental Care/Accidental Injury**

Treatment to reduce trauma and restorative services only when the result of accidental injury to sound, natural teeth and tissue that are viable, functional and free of disease. Oral surgery is covered when medically necessary as a direct result of injury, tumors or cysts. Treatment must be initiated within 60 days of accident.

No coverage for dental care, including oral surgery, as a result of poor dental hygiene.

Prior authorization by medical plan required.

**Durable Medical Equipment (DME)/Medically Necessary Disposable Supplies**

Basic equipment that meets medical needs. DME includes, but is not limited to, augmentative communication devices and manual and powered mobility devices. Includes repair and replacement due to normal wear and tear, if there is a change in medical condition or if growth-related. Disposable supplies that do not withstand prolonged use and are periodically replaced include, but are not limited to, colostomy and ureterostomy bags and prescription compression stockings.

No coverage for non-reusable disposable supplies including but not limited to bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinence pads, irrigating kits, pressure leotards, surgical leggings and support hose, over-the-counter medications and supplies including oral appliances.

Prior authorization by medical plan required for durable medical equipment over \$1,500 and/or rentals over \$500/month.

Prescription compression stockings are limited to two pairs or four individual stockings per plan year.

**Emergency Room Services**

If admitted to hospital, may be required to transfer to network facility for maximum benefit. Paid as network benefit.

**Enteral Feedings (Tube Feeding)**

Nutritional supplements that are prescribed by a physician and administered through enteral feedings, provided they are the sole source of nutrition and the member has a permanent condition, or partial nutrition during transition. This includes nutritional and electrolyte supplements and supplies related to enteral feedings (for example, feeding tubes, pumps and other materials used to administer enteral feedings).

**Flu Shot/Nasal Spray (FluMist®)**

Covered at 100% when administered in a network physician's office. When shot is obtained elsewhere, the member must submit a receipt and a Non-Network Flu Shot Reimbursement form to medical plan to receive reimbursement up to \$25. Multiple vaccinations covered if recommended by the Missouri Department of Health and Senior Services or by the Centers for Disease Control and Prevention.

**Genetic Testing or Counseling**

Genetic testing or counseling as part of treatment for a medical condition

No coverage for testing based on family history.

Prior authorization by medical plan required.



**Hair Analysis and Prostheses**

Limited to prostheses and expenses for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata or alopecia totalis for children 18 years of age or younger. Annual maximum \$200. Lifetime maximum \$3,200.

No coverage for services related to the analysis of hair unless used as a diagnostic tool to determine poisoning.

**Hearing Aids (Per Ear)**

Covered once every two years. Member pays coinsurance amount per hearing aid. If hearing aid cost exceeds the amount listed below, member is also responsible for charges over that amount.

Conventional: \$1,000

Programmable: \$2,000

Digital: \$2,500

BAHA: \$3,500

**Hearing Testing**

One hearing test per year. Additional hearing tests are covered if recommended by physician.

**Home Health Care/Palliative Services**

Prior authorization by medical plan required.

**Hospice Care**

Inpatient or Outpatient

Includes bereavement and respite care.

Prior authorization by medical plan required.

**Hospital Benefits - Inpatient Room and Board**

Based on semi-private room

- Medical (including outpatient services)
- Mental Health (including outpatient services)
- Chemical Dependency (including outpatient services)
- Observation for Medical, Mental Health or Chemical Dependency

Except for observation, prior authorization by medical plan required.

**Immunizations (Age-appropriate Adult and Pediatric)**

Specified schedule of immunizations including, but not limited to, polio, rubella, measles, mumps, tetanus, whooping cough, diphtheria, hepatitis A and B, haemophilus influenzae type B (Hib), human papillomavirus, shingles, chicken pox, meningitis and pneumonia.

Not covered when requested by third party or for travel.

Immunizations required by the Missouri Department of Health and Senior Services or recommended by the Centers for Disease Control and Prevention.

**Injections and Infusions**

Administered in the physician's office.

**Lab and X-ray**

**Mammograms**

One mammogram per year. Additional mammograms are covered if recommended by physician.

<b>Mastectomies</b> No time frame on receiving reconstructive surgery or prostheses after mastectomies necessary to restore symmetry, as recommended by physician.
<b>Maternity Coverage</b> Newborns and their mothers are allowed hospital stays of at least 48 hours after normal birth and 96 hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two-visit minimum, at least one in the home.  Prior authorization by medical plan required for maternity stays longer than 48 hours (normal delivery) or 96 hours (C-section).
<b>Mental Health/Chemical Dependency (Office Visit)</b>
<b>Nutrient Supplements</b> Formula and low-protein modified food products recommended by physician and limited only to treatment of Phenylketonuria (PKU) or any inherited disease of amino and organic acids
<b>Nutritional Counseling</b> Up to three sessions annually with registered dietitian, not limited by diagnosis. Up to three additional sessions considered with referral and medical diagnosis.  Prior authorization by medical plan required after three sessions annually.
<b>Office Visit</b> <b>Primary Care Physicians</b> <b>Specialists</b>

### **Orthotics**

#### **Therapeutic Shoes for Diabetics**

Therapeutic shoes, inserts, and/or modifications to therapeutic shoes are covered if the following criteria are met:

- The patient has diabetes mellitus; and
- The patient has one or more of the following conditions:
  - Previous amputation of the other foot, or part of either foot, or
  - History of previous foot ulceration of either foot, or
  - History of pre-ulcerative calluses of either foot, or
  - Peripheral neuropathy with evidence of callus formation of either foot, or
  - Foot deformity of either foot, or
  - Poor circulation in either foot; and
- The certifying physician who is managing the patient's systemic diabetes condition has certified that indications noted in this *Therapeutic Shoes for Diabetics* section are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes.

For adult patients meeting these criteria, coverage is limited to one of the following within one year:

- One pair of custom molded shoes (which includes inserts provided with these shoes) and 2 additional pairs of inserts; or
- One pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes).

Separate inserts may be covered and dispensed independently of diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed. This footwear must meet the definitions found in this policy for depth shoes or custom molded shoes. See Orthopedic Footwear benefit.

There is no separate payment for the fitting of the shoes, inserts, or modifications or for the certification of need or prescription of the footwear.

#### **Spinal Orthoses**

A thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the trunk; or
- To facilitate healing following an injury to the spine or related soft tissues; or
- To facilitate healing following a surgical procedure on the spine or related soft tissue; or
- To otherwise support weak spinal muscles and/or a deformed spine.

#### **Helmets**

Helmets are provided when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living. These devices are not provided for use during sports-related activities.

#### **Cranial Orthosis for Plagiocephaly**

Plagiocephaly describes an asymmetrically shaped head. Synostotic plagiocephaly (craniosynostosis) is due to the premature closure of the cranial sutures. In non-synostotic plagiocephaly, also referred to as positional or deformational, the cranial sutures remain open. Cranial orthosis is the use of a special helmet or band on the head, which aids in molding the shape of the cranium to normal. Dynamic orthotic craniotherapy, which may also be referred to as cranial molding, molding helmet, cranial banding, or cranial orthosis, is considered medically necessary only as an adjunct to operative therapy following surgery for craniosynostosis. Molding helmet therapy, including dynamic orthotic craniotherapy, is not a covered benefit for the non-operative management of positional or non-synostotic plagiocephaly.

Initial reimbursement shall cover any subsequent revisions.

**Cervical Orthoses**

A cervical orthosis is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the neck; or
- To facilitate healing following an injury to the cervical spine or related soft tissues; or
- To facilitate healing following a surgical procedure on the cervical spine or related soft tissue; or
- To otherwise support weak cervical muscles and/or a deformed cervical spine.

**Hip Orthoses**

A hip orthosis is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the hip; or
- To facilitate healing following an injury to the hip or related soft tissues; or
- To facilitate healing following a surgical procedure on the hip or related soft tissue; or
- To otherwise support weak hip muscles and/or a hip deformity.

**Knee Orthoses**

A knee orthosis is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the knee; or
- To facilitate healing following an injury to the knee or related soft tissues; or
- To facilitate healing following a surgical procedure on the knee or related soft tissue; or
- To otherwise support weak knee muscles and/or a knee deformity.

These devices are not provided solely for use during sports-related activities.

**Ankle-Foot/Knee-Ankle-Foot (AFO) Orthoses****AFOs Not Used During Ambulation**

A static AFO is covered if the following criteria are met:

- Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a non-fixed contracture); and,
- Reasonable expectation of the ability to correct the contracture; and,
- Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and,
- Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; OR
- The patient has plantar fasciitis.

If a static AFO is used for the treatment of a plantar flexion contracture, the pre-treatment passive range of motion must be measured with a goniometer and documented in the medical record. There must be documentation of an appropriate stretching program carried out by professional staff or caregiver. A static AFO and replacement interface will be denied as not medically necessary if the contracture is fixed. A static AFO and replacement interface will be denied as not medically necessary for a patient with a foot drop but without an ankle flexion contracture. A component of a static AFO that is used to address positioning of the knee or hip will be denied as not medically necessary because the effectiveness of this type of component is not established.

If a static AFO is covered, a replacement interface is covered as long as the patient continues to meet indications and other coverage rules for the splint. Coverage of a replacement interface is limited to a maximum of one (1) per 6 months. Additional interfaces will be denied as not medically necessary. A foot drop splint/recumbent positioning device and replacement interface will be denied as not medically necessary in a patient with foot drop who is non-ambulatory because there are other more appropriate treatment modalities.

**AFOs and KAFOs Used During Ambulation**

AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally.

**Knee-ankle-foot orthoses (KAFO)** are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required.

If the basic coverage criteria for an AFO or KAFO are not met, the orthosis will be denied as not medically necessary. AFOs and KAFOs that are molded-to-patient-model, or custom-fabricated, are covered for ambulatory patients when the basic coverage criteria listed above and one of the following criteria are met:

- The patient could not be fit with a prefabricated AFO, or
- The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months), or
- There is a need to control the knee, ankle or foot in more than one plane, or
- The patient has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury, or
- The patient has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

Current Procedural Terminology (CPT) L-coded additions to AFOs and KAFOs will be denied as not medically necessary if either the base orthosis is not medically necessary or the specific addition is not medically necessary.

#### **Foot Orthosis**

Custom, removable foot orthoses are considered medically necessary for members who meet the following criteria:

- Member has any of the following conditions:
  - Adults (skeletally mature feet):
    - Acute plantar fasciitis
    - Acute sport-related injuries (including: diagnoses related to inflammatory problems; e.g., bursitis, tendonitis)
    - Calcaneal bursitis (acute or chronic)
    - Calcaneal spurs (heel spurs)
    - Conditions related to diabetes (see section above on therapeutic shoes for diabetes for a complete list of medically necessary diagnoses)
    - Inflammatory conditions (i.e., sesamoiditis; submetatarsal bursitis; synovitis; tenosynovitis; synovial cyst; osteomyelitis; and plantar fascial fibromatosis)
    - Medial osteoarthritis of the knee (lateral wedge insoles)
    - Musculoskeletal/arthropathic deformities (including: deformities of the joint or skeleton that impairs walking in a normal shoe; e.g. bunions, hallux valgus, talipes deformities, pes deformities, anomalies of toes)
    - Neurologically impaired feet (including: neuroma; tarsal tunnel syndrome; ganglionic cyst; and neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease)
    - Vascular conditions (including: ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), chronic thrombophlebitis).
  - Children (skeletally immature feet):
    - Hallux valgus deformities
    - In-toe or out-toe gait
    - Musculoskeletal weakness (e.g., pronation, pes planus)
    - Structural deformities (e.g., tarsal coalitions)
    - Torsional conditions (e.g., metatarsus adductus, tibial torsion, femoral torsion)

#### **Orthopedic Footwear**

Orthopedic footwear is covered for adults if it is an integral part of a covered leg brace. Oxford shoes

are covered in these situations. Other shoes, e.g. high top, depth inlay or custom for non-diabetics, etc., are also covered if they are an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace. Heel replacements, sole replacements, and shoe transfers involving shoes on a covered brace are also covered. Inserts and other shoe modifications are covered if they are on a shoe that is an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace.

A shoe and related modifications, and heel/sole replacements, are covered only when the shoe is an integral part of a brace. A matching shoe which is not attached to a brace is non-covered.

Shoes which are incorporated into a brace must be billed by the same supplier billing for the brace.

#### **Upper Limb Orthoses**

An upper limb orthosis is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the joint(s)
- To facilitate healing following an injury to the joint(s) or related soft tissues
- To facilitate healing following a surgical procedure on the joint(s) or related soft tissue

#### **Elastic Supports**

Elastic supports are covered when they are ordered for one of the following indications:

- Severe or incapacitating vascular problems, such as
  - acute thrombophlebitis
  - massive venous stasis
  - pulmonary embolism
- Venous insufficiency
- Varicose veins
- Edema of lower extremities
- Edema of pregnancy
- Lymphedema

#### **Trusses**

Trusses are covered when a hernia is reducible with the application of a truss.

#### **Orthotic-Related Supplies**

Orthotic-related supplies are covered when the device with which it is used is covered and they are necessary for the function of the orthotic device.

#### **Cast Boot, Post-Operative Sandal or Shoe, Healing Shoe**

A cast boot or post-operative sandal or shoe is covered when it is medically necessary for one of the following indications:

- to protect a cast from damage during weight-bearing activities following injury or surgery;
- to provide appropriate support and/or weight-bearing surface to a foot following surgery;
- to promote good wound care and healing via appropriate weight distribution and foot protection;
- or
- when the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

#### **Specific Exclusions**

Non-covered devices and supplies include, but are not limited to, all of the following:

- Experimental or investigational devices
- Items for the patient's comfort or convenience or for the convenience of the patient's caregiver(s)
- Items to have on hand for backup or duplicates to have available at various locations
- Devices and supplies for residents of nursing facilities
- Equipment or supplies covered by another agency

#### **Replacing Orthotic Devices**

**When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item. A replacement is subject to review of medical necessity. The plan will take into account the anticipated life expectancy of the device.**

**Prior authorization by medical plan required for orthotics over \$1,000**

**Outpatient Diagnostic Procedures**

**Including, but not limited to, diagnostic sigmoidoscopies, endoscopies, sleep studies, ultrasounds, electroencephalograms (EEGs) and electrocardiograms (EKGs)**

**Oxygen**

**Outpatient**

**Go to DURABLE MEDICAL EQUIPMENT in this section.**

**Prior authorization by medical plan required.**

**Physical, Speech and Occupational Therapy and Rehabilitation Services - Outpatient**

**Up to 60 combined visits allowed per incident if showing significant improvement. Aquatic therapy must be performed by physical therapist to be covered.**

**Speech Therapy:**

**Covered as medically necessary for either of the following:**

- **A prescribed course of speech therapy by an appropriate healthcare provider for the treatment of a severe impairment of speech/language and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests that measure the extent of the impairment, performance deviation, and language and pragmatic skills assessment levels.**
- **A prescribed course of voice therapy by an appropriate healthcare provider for a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery).**

**When all of the following criteria are met:**

- **The treatment being recommended has the support of the treating physician;**
- **The therapy being ordered requires the one-to-one intervention and supervision of a speech-language pathologist;**
- **The therapy plan includes specific tests and measures that will be used to document significant progress every two weeks;**
- **Meaningful improvement is expected from the therapy and**
- **The treatment includes a transition from one-to-one supervision to an individual or caregiver provided maintenance program upon discharge.**

**Speech or voice therapy is not covered in any of the following situations:**

- **Any computer-based learning program for speech or voice training purposes**
- **School speech programs**
- **Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy)**
- **Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs)**
- **Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver**

- Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work
- Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences
- Therapy or treatment provided to improve or enhance job, school or recreational performance
- Long-term rehabilitative services when significant therapeutic improvement is not expected

**Physical Therapy:**

Covered as a prescribed course of physical therapy by an appropriate healthcare provider as medically necessary when all of the following criteria are met:

- The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect or surgery;
- The program is expected to result in significant therapeutic improvement over a clearly defined period of time and
- The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.

Physical therapy is not covered for the following:

- Treatment provided to prevent or slow deterioration in function or prevent reoccurrences
- Treatment intended to improve or maintain general physical condition
- Long-term rehabilitative services when significant therapeutic improvement is not expected
- Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g. occupational therapy)
- Work hardening programs
- Back school
- Vocational rehabilitation programs and any program with the primary goal of returning an individual to work
- Group physical therapy (because it is not one-on-one, individualized to the specific person's needs)
- Services for the purpose of enhancing athletic performance or for recreation

**Occupational Therapy:**

Covered as prescribed course of occupational therapy by an appropriate healthcare provider as medically necessary when all of the following criteria are met:

- The program is designed to improve or compensate for lost or impaired physical functions, particularly those impacting activities of daily living, resulting from illness, injury, congenital defect, or surgery;
- The program is expected to result in significant therapeutic improvement over a clearly defined period of time and
- The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.

Occupation Therapy is not covered for the following:

- Treatment provided to prevent or slow deterioration in function or prevent reoccurrences
- Treatment intended to improve or maintain general physical condition



- Long-term rehabilitative services when significant therapeutic improvement is not expected
- Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g. physical therapy)
- Work hardening programs
- Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work
- Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs)
- Driving safety/driver training

**Prior authorization by medical plan required after 60 combined visits per incident.**

**Physician Charges**

**Preventive Services**

- Services recommended by the U.S. Preventive Services Task Force (categories A and B)
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration
- Preventive care and screenings for women supported by the Health Resources and Services Administration

**Annual physical exams (Well man, woman and child) -  
one per calendar year**

**Age-specific cancer screenings:**

- Mammograms
- Pap smears
- Prostate cancer screenings
- Colorectal screenings
- Colonoscopy and sigmoidoscopy screenings

**For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.**

**Prostheses (Prosthetic Devices)**

**Basic equipment that meets medical needs**

**Repair and replacement not covered unless due to normal wear and tear, if there is a change in medical condition or if growth-related.**

**Prior authorization by medical plan required for prostheses over \$1,000.**

**Skilled Nursing Facility**

**Benefits are limited to 120 days per calendar year.**

**Prior authorization by medical plan required.**

**Surgery (Inpatient and Outpatient)****Includes sterilization****Prior authorization by medical plan required for outpatient surgeries:**

- Potential cosmetic surgery
- Sleep Apnea surgery
- Implantable Stimulators
- All outpatient surgeries with procedure codes ending in T (temporary codes used for data collection, experimental, investigational or unproven surgeries)
- Outpatient spinal surgeries including but not limited to artificial disc replacement, fusions, non-pulsed radiofrequency denervation, vertebroplasty/kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure.

**Oral surgery**

- Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological exams
- Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth
- Reduction of fractures and dislocations of the jaw
- Excision of exostosis of jaws and hard palate
- External incision and drainage of cellulitis
- Incision of accessory sinuses, salivary glands or ducts
- Frenectomy

**Transplants**

**When neither experimental nor investigational and medically necessary: bone marrow, cornea, kidney, liver, heart, lung, pancreas, intestinal or any combination. Includes services related to organ procurement and donor expenses if not covered under another plan.**

**Contact medical plan for arrangements, prior authorization and transplant network.**

**Travel, if approved, is limited to \$10,000 maximum per transplant.**

**Network**

**Includes travel and lodging allowance for recipient and his or her immediate family travel companion (younger than 19, both parents) if transplant facility is more than 100 miles from residence.**

**Lodging: Maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to [www.gsa.gov](http://www.gsa.gov) for per diem rates.**

**Travel: IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).**

**Meals: Not covered.**

**Prior authorization by medical plan required.**

**Non-network**

**Reimbursement limited to maximum schedule. Charges above the maximum are your responsibility and do not apply to your deductible or out-of-pocket maximum.**

**Travel, lodging and meals not covered.**

**Prior authorization by medical plan required.**

**Urgent Care**

**Paid as network benefit.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed rule covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership  
EMERGENCY AMENDMENT**

**22 CSR 10-3.060 [PPO 300 Plan,] PPO [500] 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP[, and Copay] Plan Limitations.** The Missouri Consolidated Health Care Plan is deleting sections (2), (33), (48), (50), (52), and (57); amending the rule title, rule purpose, and sections (1), (7), (8), (11)–(13), (26), (28), (30), (31), (37), (45), (49), (51), and (53); adding new sections (3), (6), (7), (9)–(11), (15), (16), (30), (33), (37), (41), (42), (48), (54), (56), and (63); and renumbering as necessary.

*PURPOSE: This amendment includes changes by the board of trustees in regard to the limitations and exclusions of the Missouri Consolidated Health Care Plan PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP Plan.*

*PURPOSE: This rule establishes the limitations and exclusions of the Missouri Consolidated Health Care Plan [PPO 300 Plan,] PPO [500] 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP[, and/or Copay] Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges *[or within any of the sections of this rule]*. In addition, the items specified in this rule are not covered, unless expressly stated otherwise and then only to the extent expressly provided herein.

*[(2) If applicable, all hospitalizations, outpatient treatment for*

*chemical dependency, or mental and nervous disorder that do not receive prior authorization as described in 22 CSR 10-2.045, reimbursement will be reduced by ten percent (10%) of reasonable and customary charges.]*

*[(3)](2) Abortion—other than situations where the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.*

(3) Acts of war—**injury or illness caused, or contributed to, by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.**

(6) Assistant surgeon services—**not covered unless determined to meet the clinical eligibility for coverage under the plan.**

(7) Athletic trainer services—**services by a licensed athletic trainer not covered.**

*[(6)](8) Autopsy.*

(9) Bariatric procedures—**not covered except for members who have undergone bariatric procedures before December 31, 2010, that were approved by the medical plan will receive follow-up care until December 31, 2011. Revisions and corrections of bariatric procedures are covered only when the revision is used to treat life-threatening complications (e.g., wound infection, abscess, dehiscence, gastric leaking, and embolism).**

(10) Blood donor expenses—**not covered.**

(11) Blood pressure cuffs/monitors—**not covered.**

*[(7)](12) Blood storage[,]**—not covered**, including whole blood, blood plasma, and blood products.*

*[(8)](13) Breast augmentation mammoplasty—**not covered unless associated with breast surgery following a medically necessary mastectomy incurred secondary to active disease.***

*[(9)](14) Care received without charge.*

(15) Charges resulting from the failure to appropriately cancel a scheduled appointment.

(16) Childbirth classes.

*[(10)](17) Comfort and convenience items.*

*[(11)](18) Cosmetic, plastic, reconstructive, or restorative surgery—unless medically necessary to repair a functional disorder caused by disease[,] **or injury, or congenital defect or abnormality (for a participant under the age of nineteen (19)), or to restore symmetry following a mastectomy.***

*[(12)](19) Custodial or domiciliary care—includes services and supplies that assist members in the activities of daily living like walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets *[and]*; supervision of medication that is usually self-administered; **or other services that can be provided by persons without the training of a health care provider.***

*[(13)](20) Dental—treatment must be initiated within sixty (60) days of accident. Limited to treatment of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of disease. Oral surgery is covered only when medically necessary as a direct result from injury, tumors, or cysts. Dental care, including oral*

surgery, as a result of poor dental hygiene is not covered. Extractions of bony or partial bony impactions are excluded.

**[(14)](21)** Durable medical equipment and disposable supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings, and support hose. Over-the-counter medications and supplies. Prescription compression stockings are limited to two (2) pairs of four (4) individual stockings per plan year.

**[(15)](22)** Educational or psychological testing—not covered unless part of a treatment program for covered services.

**[(16)](23)** Examinations requested by a third party.

**[(17)](24)** Excessive charges—any otherwise eligible expenses that exceed the maximum allowance or benefit limit.

**[(18)](25)** Exercise equipment.

**[(19)](26)** Experimental services or investigational services—experimental or investigational services, procedures, supplies, or drugs as determined by the claims administrator are not covered, except clinical trials for cancer treatment as specified by law.

**[(20)](27)** Eye glasses and contact lenses—charges incurred in connection with the fitting of eye glasses or contact lenses except for initial placement immediately following cataract surgery.

**[(21)](28)** Eye services—health services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

**[(22)](29)** Services obtained at a government facility—not covered if care is provided without charge.

**(30) Gender reassignment—health services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment.**

**[(23)](31)** Hair analysis, wigs, and hair transplants—services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also, hairstyling wigs, hairpieces, and hair prostheses, including those ordered by a participating provider, are not covered. Such items and services are not covered except for members ages eighteen (18) and under with alopecia as specified by law. Subject to two hundred dollar (\$200) annual maximum and three thousand two hundred dollar (\$3,200) lifetime maximum.

**[(24)](32)** Health and athletic club membership—including costs of enrollment.

**(33) Home births.**

**[(25)](34)** Immunizations requested by third party or for travel.

**[(26)](35) Infertility treatment.***[—Infertility treatments are limited to in-vivo (intrauterine, intracervical, intravaginal fertilization). Those health services and associated expenses for the treatment of infertility are not covered, including reversal of voluntary sterilization, intracytoplasmic sperm injection (ICSI), in vitro fertilization, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT) procedures; embryo transport; donor sperm and related cost for collec-*

*tion; no cryopreservation of sperm or eggs; and non-medically necessary amniocentesis.]*

**[(27)](36)** Level of care, if greater than is needed for the treatment of the illness or injury.

**(37) Long-term care.**

**[(28)](38)** Medical care and supplies—not to the extent that they are payable under—

(A) A plan or program operated by a national government or one (1) of its agencies; or

(B) Any state's cash sickness or similar law, including any group insurance policy approved under such law.

**[(29)](39)** Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the *[subscriber]* **participant**, such as a spouse, parent, child, sibling, or brother/sister-in-law.

**[(30)](40)** Military service connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

**(41) Never events—twenty-eight (28) occurrences on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting. They are defined as adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.**

**(42) Nocturnal enuresis alarm.**

**[(31)](43)** Non-network providers—subject to **higher** deductible and non-network coinsurance.

**[(32)](44)** Not medically necessary services—with the exception of preventive services.

**[(33) Obesity—medical and surgical intervention is not covered, unless the member meets the definition of severe morbid obesity as defined in 22 CSR 10-3.010 and satisfies all requirements described in the plan. Bariatric surgery will only be covered when prior authorization is received from the medical plan.**

**(A) Bariatric surgery additional qualifying criteria—**

1. Presence of severe morbid obesity that has persisted for at least five (5) years defined as body mass index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions will be considered based on clinical review;

2. Member must be eighteen (18) years of age or older;

3. Documented evidence of at least two (2) failed attempts at weight loss each with a minimum duration of at least six (6) months with the member achieving at least a ten percent (10%) weight loss and meeting the following additional criteria: one (1) attempt must be in a physician-supervised weight loss program and fully documented in the physician's record; the program must use a multidisciplinary approach including dietician consultation, low-calorie diet, increased physical activity, and behavioral modification; nationally recognized program such as Jenny Craig or Weight Watchers (This does not include self-directed low-calorie diets such as the Atkins Diet or South Beach Diet.); and the

*most recent attempt must have been within the twelve (12)-month period prior to the requested surgery;*

4. *Documented evidence the member is on a nutrition and exercise program immediately prior to the surgery request;*

5. *Evidence the member and the attending physician have a life-long plan for compliance with lifestyle modification requirements;*

6. *Documentation the member has completed a psychological evaluation and, if appropriate, behavior modification and should be free of major psychiatric diagnosis or a current behavior which would significantly reduce long-term effectiveness of the proposed treatment; and*

7. *Procedure must be performed at a Centers of Excellence (COE) facility for Bariatric Surgery as determined by the Centers for Medicare and Medicaid Services.*

(B) *Network services are limited to one (1) operative procedure for the treatment of obesity per lifetime. Non-network obesity services are not covered.*

(C) *Revisions and corrections of bariatric procedures only when the revision or correction is used to treat life-threatening complications (e.g., wound infection, abscess, dehiscence, gastric leaking, and embolism). Coverage is limited to the following bariatric procedures: Roux-en-Y Gastric Bypass—open and laparoscopic (RYGBP), Laparoscopic Adjustable Gastric Banding (LAGB), and Open and Laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS).]*

[(34)](45) Orthognathic surgery.

[(35)](46) Orthoptics.

[(36)](47) Other charges—no coverage for charges that would not be incurred if the subscriber was not covered. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan. Miscellaneous service charges—telephone consultations, charges for failure to keep scheduled appointment (unless the scheduled appointment was for a mental health service), or any late payment charge.

(48) Outpatient birthing centers.

[(37)](49) Over-the-counter medications—except for insulin and drugs recommended by the U.S. Preventive Services Task Force (Categories A and B) as prescribed by a physician and included on the formulary through the pharmacy benefit.

[(38)](50) Over-the-counter supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings, and support hose.

[(39)](51) Physical fitness.

[(40)](52) Physical, speech, and occupational therapy—health services and associated expenses for development delay. Treatment for disorders relating to delays in learning, motor skills, and communications.

[(41)](53) Private duty nursing.

(54) Prognathic and maxillofacial surgery.

[(42)](55) Prosthetic repair or replacement—not covered unless due to normal wear and tear, if there is a change in medical condition, if growth related, or medically necessary.

(56) Self-inflicted injuries—not covered unless related to a mental diagnosis.

[(43)](57) Services not specifically included as benefits.

[(44)](58) Services rendered after termination of coverage—those services otherwise covered under the agreement, but rendered after the date coverage under the agreement terminates, including services for medical conditions arising prior to the date individual coverage under the agreement terminates.

[(45)](59) Stimulators (for bone growth)—not covered unless prior authorized by claims administrator and clinical eligibility is met.

[(46)](60) Surrogacy—pregnancy coverage is limited to plan member.

[(47)](61) Temporo-Mandibular Joint Syndrome (TMJ).

[(48)] Third-party examinations.]

[(49)](62) Tobacco cessation—patches and gum are not covered. [There is a limited benefit available under the pharmacy benefit.]

(63) Transplant benefits at a non-network facility. Non-network facility charges and payments for transplants are limited to the following maximum only:

- (A) Allogenic Bone Marrow—\$143,000;
- (B) Autologous Bone Marrow—\$121,000;
- (C) Heart—\$128,000;
- (D) Heart and Lung—\$133,000;
- (E) Lung—\$151,000;
- (F) Kidney—\$54,000;
- (G) Kidney and Pancreas—\$97,000; and
- (H) Liver—\$153,000.

[(50)] Transplants—double listing—payment only for one (1) evaluation up to time of actual transplant.]

[(51)](64) Transplants—travel expense—requires authorization from medical plan. Limited to ten thousand dollar (\$10,000) maximum per transplant when accessing network services. Travel expenses include travel and lodging allowance for recipient and his/her immediate family travel companion. When a participant is younger than nineteen (19) years of age, travel expenses are covered for both parents. Transplant facility must be more than one hundred (100) miles from the recipient's residence. Meals are not covered.

[(52)] Transsexual surgery—health services and associated expenses in the transformation operations regardless of any diagnosis or gender role disorientation or psychosexual orientation or any treatment or studies related to sex transformation. Also excludes hormonal support for sex transformation.]

[(53)](65) Travel expenses—not covered [unless authorized by claims administrator] except for transplants in a network facility.

[(54)](66) Trimming of nails, corns, or calluses—not covered except for persons being treated for diabetes, peripheral vascular disease, or blindness.

[(55)](67) Usual, Customary, and Reasonable (UCR)—charges exceeding UCR are not covered, as applicable to the non-network benefit.

[(56)](68) Vitamins and nutrients—limited to prenatal agents for pregnancy, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents through the pharmacy benefit.

[(57)] War or insurrection—liability to provide services limited in the event of a major disaster, epidemic, riot, or other circumstances beyond the control of the plan.]

[(58)](69) Workers' compensation—charges for services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation [of similar program].

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-3.075 Review and Appeals Procedure.** The Missouri Consolidated Health Care Plan is deleting section (1), amending and renumbering sections (2)–(6), and adding new sections (1) and (3).

*PURPOSE: This amendment changes the policy of the board of trustees in regard to review and appeals procedures for participation in the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and was terminated on January 20, 2011.*

[(1)] When any participant shall suffer any injury or sickness giving rise to claim under these rules, s/he shall have free choice of providers practicing legally in the location in which service is provided to the end that a provider/patient relationship shall be maintained. Reimbursement will be in accordance with the benefit provisions of the type of coverage chosen by the participant.]

**(1) Medical and Pharmacy Service Appeals.** There is an internal appeals process through the claims administrators for urgent care, pre-service, and post-service claims that a member may request reconsideration of an adverse benefit determination. There is a two (2)-level internal appeal process for medical services and a one (1)-level appeal process for pharmacy services. Once the internal appeal process is complete, the member may further appeal through an external review process.

**(A)** Claims are divided into two (2) types: pre-service and post-service claims.

**1. Pre-service claims** are requests for approval that the health plan contractor or claims administrator requires a member to obtain before getting medical care, such as prior authorization or a decision on whether a treatment or procedure is medically necessary.

**A. Pre-service claims** must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than fifteen (15) days from the date the health plan contractor or claims administrator has received the claim. The health plan contractor or claims administrator may extend the time period up to an additional fifteen (15) days if, for reasons beyond the claims administrator's control, the decision cannot be made within the first fifteen (15) days. The health plan contractor or claims administrator must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the health plan contractor or claims administrator. The health plan contractor or claims administrator then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

**B. Urgent care claims** are a special type of pre-service claim that requires a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within twenty-four (24) hours and will follow-up with written confirmation of the decision.

**2. Post-service claims** are all other claims for benefits including claims after medical services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

**A. Post-service claims** must be decided within a reasonable period of time, but not later than thirty (30) days after the claims administrator has received the claim. If, because of reason beyond the health plan contractor or claims administrator's control, more time is needed to review the claim, the claims administrator may extend the time period up to an additional fifteen (15) days. The health plan contractor or claims administrator must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the health plan contractor or claims administrator. The claims administrator then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

[(2)]/B. The [plan administrator, agent] health plan contractor or claims administrator, upon receipt of a notice of request,

shall furnish to the employee the forms as are usually furnished for filing proof/s/ of loss. If the forms are not furnished within thirty (30) days after the giving of such notice, the employee shall be deemed to have complied with the requirement as to proof of loss upon submitting, within the time fixed for filing proof/s/ of loss, written proof covering the occurrence, the character, and the extent of the loss for which request is made.

[(3)]C. Written proof of claims incurred should be furnished to the **health plan contractor** or claims administrator as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the claims administrator before they are paid.

[(4)]D. In the case of medical benefits, the **health plan contractor** or claims administrator will send written notice of any amount applied toward the deductible as well as any payments made. The claims administrator may also send a request for additional information or material to support the claim, along with reasons why this information is necessary.

E. The member is entitled to receive, upon written request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim in question.

F. A first level appeal for medical and pharmacy services of an adverse benefit determination shall be submitted in writing within one hundred eighty (180) days of the date on the original claim decision notice.

(I) Submit the first level appeal to the health plan contractor or claims administrator in writing to—

(a) UMR Claims Appeal Unit, PO Box 30546, Salt Lake City, UT 84130-0546;

(b) Mercy Health Plans, Attn: Corporate Appeals, 14528 S. Outer 40 Road, Suite 300, Chesterfield, MO 63017; or

(c) Express Scripts, Clinical Appeals—MH3, 6625 West 78th Street, BL0390, Bloomington, MN 55439 or fax to 1-877-852-4070.

(II) Include any additional information or documentation to support the reason the original claim decision should be overturned.

(III) The first level appeal will be reviewed by the health plan contractor or claims administrator who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved.

(IV) The first level appeal shall be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the health plan contractor or claims administrator received the first level appeal request.

G. An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care.

(I) Submit the expedited appeal to the health plan contractor or claims administrator by telephone or fax to—

(a) UMR telephone 1-866-868-7758 or by fax to 1-866-912-8464, Attention: Appeals Unit;

(b) Mercy Health Plans telephone 1-800-830-1918, ext. 2394 or by fax to 1-314-214-3233, Attention: Corporate Appeals; or

(c) Express Scripts, Clinical Appeals—MH3, 6625 West 78th Street, BL0390, Bloomington, MN 55439 or fax to 1-877-852-4070.

(II) The expedited appeal will be reviewed by the health plan contractor or claims administrator who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved.

(III) The expedited appeal will be responded to within seventy-two (72) hours after receiving a request for an expedited

review with written confirmation of the decision within three (3) working days of providing notification of the determination.

H. A second level appeal for medical services shall be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination.

(I) Submit the second level appeal to the health plan contractor or claims administrator in writing to—

(a) UMR Claims Appeal Unit, PO Box 8086, Wausau, WI 54402-8086; or

(b) Mercy Health Plans, Attn: Corporate Appeals, 14528 S. Outer 40 Road, Suite 300, Chesterfield, MO 63017.

(II) Include any additional information or documentation to support the reason the first level appeal decision should be overturned.

(III) The second level appeal will be reviewed by the health plan contractor or claims administrator who will have someone review the appeal who was not involved in the original decision or first level appeal and will consult with a qualified medical professional if a medical judgment is involved.

(IV) The second level appeal shall be responded to in writing to the member within sixty (60) days for post service claims and thirty (30) days for pre-service claims from the date the claims administrator received the second level appeal request.

[(5)](2) All members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the health plan contractor or claims administrator applicable to the member. *[Appeals to the health plan contractor or claims administrator must be made in writing within one hundred eighty (180) days of receiving the denial or notice which gave rights to the appeal. Only after these procedures have been exhausted may the member appeal directly to the Missouri Consolidated Health Care Plan to review the decision of the health plan contractor or claims administrator.]* Following the completion of the internal appeal process, an external appeal for medical and pharmacy services is available through the Missouri Department of Insurance, Financial Institutions and Professional Registration. Submit written request for an external appeal to Missouri DIFP, Attn: Consumer Affairs, PO Box 690, Jefferson City, MO 65102-0690. An external appeal request may be requested online at <https://insurance.mo.gov/consumer/complaints/consumercomplaint.php> and may also be faxed to 573-526-4898.

(3) Dental and Vision Plan Appeals. Appeals involving services from the dental and vision plans are solely through the dental and vision plan contractor.

[(A)](4) *[Appeals to MCHCP shall be submitted in writing within forty-five (45) days of receiving the final decision from the member's health care plan contractor or claims administrator, specifically identifying the issue to be resolved.]* Administrative appeals involve issues regarding MCHCP eligibility, plan effective dates, premium payments, Lifestyle Ladder program, and plan choices. Administrative appeals shall be submitted in writing *[as soon as possible following]* within one hundred eighty (180) days from the date of the notice of administrative decision or written *[or verbal notice of an MCHCP staff]* denial of the member's administrative request.

(A) All *[appeals and]* administrative appeals shall be addressed to:

Attn: Appeal  
Board of Trustees  
Missouri Consolidated Health Care Plan  
PO Box 104355  
Jefferson City, MO 65110-4355



(B) The board may, in its discretion, choose to conduct a hearing regarding a member's **administrative** appeal. If the board decides a hearing is needed to render a decision, it may utilize a hearing officer or committee to conduct a fact-finding hearing and make proposed findings of fact and conclusions of law. In such cases—

1. The hearing will be scheduled by the MCHCP;
2. The parties to the hearing will be the insured and the applicable health plan or MCHCP staff in self-insured situations;
3. All parties shall be notified in writing of the date, time, and location of the hearing;
4. All parties shall have the right to appear at the hearing and submit written or oral evidence. The appealing party shall be responsible for all copy charges incurred by MCHCP in connection with any documentation that must be obtained through the MCHCP. These fees will be reimbursed should the party prevail in his/her appeal. They may cross-examine witnesses. They need not appear and may still offer written evidence. The strict rules of evidence shall not apply;
5. The party appealing to the board shall carry the burden of proof; and
6. The hearing officer shall propose findings of fact and conclusions of law, along with its recommendation, to the board. Copies of the summary, findings, conclusions, and recommendations shall be sent to all parties.

(C) The board may, but is not required to, review the transcript of the hearing and solicit additional evidence and argument. It will review the summary of evidence and the proposed findings of fact and conclusions of law and shall then issue its final decision on the matter.

1. All parties shall be given a written copy of the board's final decision.
2. All parties shall be notified that, if they feel aggrieved by the final decision, they shall have the right to seek judicial review of the decision as provided by Missouri law.

(D) Administrative decisions made solely by MCHCP may be appealed directly to the board of trustees, by either a member or health plan contractor providing a fully-insured product.

1. All the provisions of this rule, where applicable, shall apply to these appeals.
2. The parties to such appeal shall be the appellant and the MCHCP shall be respondent.

3. The appellant, if aggrieved by the final decision of the board, shall have the right of appeal as stated in subsection [(5)(C)] (4)(C) herein.

[(6)](E) In reviewing **administrative** appeals, notwithstanding any other rule, the board and/or staff may grant any **administrative** appeal/s/ when there is credible evidence to support approval under the following guidelines:/.

[(A)]1. Newborns—If a member currently has coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within three (3) months of the child's date of birth.

[(B)]2. Agency error—MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office, the MCHCP, or plan offered by MCHCP that was no fault of the member.

[(C)]3. Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year.

[(D)]4. Non-payment—MCHCP may allow one (1) reinstatement for terminations due to non-payment (per lifetime of account).

[(E)]5. Reinstatement before termination—MCHCP may reinstate coverage if request is received prior to end of current coverage.

[(F)]6. Termination of dental and/or vision coverage—MCHCP may terminate dental and/or vision coverage if request is received

prior to February 1 and if no claims have been made/paid for January.

[(G)]7. Proof of eligibility—MCHCP may approve late receipt of proof-of-eligibility documentation if MCHCP can verify that it took an unreasonable amount of time for public entity (county or state) to provide subscriber with requested documentation.

[(H)]8. Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage.

[(I)]9. Loss of coverage notice—MCHCP may approve late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.

[(J)]10. *[Lifestyle Ladder]* **Wellness Program** participation—MCHCP may deny all appeals regarding continuation of participation in *[Lifestyle Ladder]* the **Wellness Program** due to failure of member's participation.

[(K)]11. Proof of open enrollment confirmation—MCHCP may approve appeals if subscriber is able to provide a confirmation sheet from open enrollment. However, such administrative appeals must be received by MCHCP on or before the last day of February.

[(L)]12. Substantiating evidence—MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period.

[(M)]13. New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Amended: Filed Dec. 22, 2008, effective June 30, 2009. Amended: Filed Feb. 17, 2010, effective Aug. 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, terminated Jan. 20, 2011. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**ORDER TERMINATING EMERGENCY  
AMENDMENT**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the executive director hereby terminates an emergency amendment effective January 20, 2011, as follows:

**22 CSR 10-3.075 Review and Appeals Procedure is terminated.**

A notice of emergency rulemaking containing the text of the emergency amendment was published in the *Missouri Register* on February 1, 2011 (MoReg 431-433).

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-3.075 Review and Appeals Procedure.** The Missouri Consolidated Health Care Plan is amending the rule purpose and all sections of this rule.

**PURPOSE:** *This amendment changes the policy of the board of trustees in regard to review and appeals procedures for participation in, and coverage of services under, the Missouri Consolidated Health Care Plan.*

**PURPOSE:** *This rule establishes the policy of the board of trustees in regard to review and appeals procedures for participation in, and coverage of services under, the Missouri Consolidated Health Care Plan.*

**EMERGENCY STATEMENT:** *This emergency amendment must be in place by January 20, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 20, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed January 1, 2011, becomes effective January 20, 2011, and expires on June 29, 2011.*

*[(1) When any participant shall suffer any injury or sickness giving rise to claim under these rules, s/he shall have free choice of providers practicing legally in the location in which service is provided to the end that a provider/patient relationship shall be maintained. Reimbursement will be in accordance with the benefit provisions of the type of coverage chosen by the participant.*

*(2) The plan administrator, agent, or claims administrator, upon receipt of a notice of request, shall furnish to the employee the forms as are usually furnished for filing proofs of loss. If the forms are not furnished within thirty (30) days after the giving of such notice, the employee shall be deemed to have complied with the requirement as to proof of loss upon submitting, within the time fixed for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which request is made.*

*(3) Written proof of claims incurred should be furnished to the claims administrator as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the claims administrator before they are paid.*

*(4) In the case of medical benefits, the claims administrator will send written notice of any amount applied toward the*

*deductible as well as any payments made. The claims administrator may also send a request for additional information or material to support the claim, along with reasons why this information is necessary.*

*(5) All members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the health plan contractor or claims administrator applicable to the member. Appeals to the health plan contractor or claims administrator must be made in writing within one hundred eighty (180) days of receiving the denial or notice which gave rights to the appeal. Only after these procedures have been exhausted may the member appeal directly to the Missouri Consolidated Health Care Plan to review the decision of the health plan contractor or claims administrator.*

*(A) Appeals to MCHCP shall be submitted in writing within forty-five (45) days of receiving the final decision from the member's health care plan contractor or claims administrator, specifically identifying the issue to be resolved. Administrative appeals shall be submitted in writing as soon as possible following written or verbal notice of an MCHCP staff denial of the member's administrative request. All appeals and administrative appeals shall be addressed to:*

*Attn: Appeal  
Board of Trustees  
Missouri Consolidated Health Care Plan  
PO Box 104355  
Jefferson City, MO 65110*

*(B) The board may, in its discretion, choose to conduct a hearing regarding a member's appeal. If the board decides a hearing is needed to render a decision, it may utilize a hearing officer or committee to conduct a fact-finding hearing and make proposed findings of fact and conclusions of law. In such cases—*

- 1. The hearing will be scheduled by the MCHCP;*
- 2. The parties to the hearing will be the insured and the applicable health plan or MCHCP staff in self-insured situations;*
- 3. All parties shall be notified in writing of the date, time, and location of the hearing;*

- 4. All parties shall have the right to appear at the hearing and submit written or oral evidence. The appealing party shall be responsible for all copy charges incurred by MCHCP in connection with any documentation that must be obtained through the MCHCP. These fees will be reimbursed should the party prevail in his/her appeal. They may cross-examine witnesses. They need not appear and may still offer written evidence. The strict rules of evidence shall not apply;*

- 5. The party appealing to the board shall carry the burden of proof; and*

- 6. The hearing officer shall propose findings of fact and conclusions of law, along with its recommendation, to the board. Copies of the summary, findings, conclusions, and recommendations shall be sent to all parties.*

*(C) The board may, but is not required to, review the transcript of the hearing and solicit additional evidence and argument. It will review the summary of evidence and the proposed findings of fact and conclusions of law and shall then issue its final decision on the matter.*

- 1. All parties shall be given a written copy of the board's final decision.*

- 2. All parties shall be notified that if they feel aggrieved by the final decision, they shall have the right to seek judicial review of the decision as provided by Missouri law.*

*(D) Administrative decisions made solely by MCHCP may*

*be appealed directly to the board of trustees, by either a member or health plan contractor providing a fully-insured product.*

*1. All the provisions of this rule, where applicable, shall apply to these appeals.*

*2. The parties to such appeal shall be the appellant and the MCHCP shall be respondent.*

*3. The appellant, if aggrieved by the final decision of the board, shall have the right of appeal as stated in subsection (5)(C) herein.]*

**(1) Claims Submissions and Initial Benefit Determinations.**

(A) Members shall use the claims and administration procedures established by the vendor administering the particular service for which coverage, authorization, or payment is sought.

(B) Medical and pharmacy service claims are divided into three (3) types: pre-service, post-service, and concurrent claims.

1. Pre-service claims are requests for approval that the plan or vendor requires a member to obtain before getting medical care or filling a prescription, such as prior authorization or a decision whether a treatment, procedure, or medication is medically necessary.

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than fifteen (15) days from the date the vendor receives the claim. The vendor may extend the time period up to an additional fifteen (15) days if, for reasons beyond the vendor's control, the decision cannot be made within the first fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

B. Urgent care claims are a special type of pre-service claim that require a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within seventy-two (72) hours. Written confirmation of the decision will be sent by the vendor as soon as possible thereafter.

2. Post-service claims are all other claims for services including claims after medical or pharmacy services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

A. Post-service claims must be decided within a reasonable period of time, but not later than thirty (30) days after the vendor receives the claim. If, because of reasons beyond the vendor's control, more time is needed to review the claim, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

3. Concurrent claims are claims related to an ongoing course of previously-approved treatment. If the plan or vendor has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. The plan or vendor will notify a member in writing prior to reducing or ending a previously-approved course of treatment in sufficient time to allow the member or the member's provider

to appeal and obtain a determination before the benefit is reduced or terminated.

(C) Claims incurred should be furnished to the vendor by the provider or the member as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the vendor before they are paid.

(D) If a member, or a provider or authorized representative on behalf of a member, submits a request for coverage or a claim for services that is denied in whole or in part, the member will receive an initial denial notice within the time frames described in this rule that will include the following information:

1. The reasons for the denial;

2. Reference to the plan provision, regulation, statute, clinical criteria, or guideline on which the denial was based with information as to how the member can obtain a copy of the provision, regulation, statute, clinical criteria, or guideline free of charge;

3. A description of any documentation or information that is necessary for the member to provide if documentation or information is missing and an explanation as to why the documentation or information is needed, if applicable; and

4. Information as to steps the member can take to submit an appeal of the denial.

**(2) General Appeal Provisions.**

(A) All individuals seeking review or appeal of a decision of the plan, plan administrator, claims administrator, or any vendor shall follow the procedures applicable to the type of decision appealed as set forth in this rule.

(B) All appeals must be submitted in writing to the appropriate reviewer as established in this rule by the member, the individual seeking review, or his/her authorized representative.

(C) Unless specifically provided otherwise in this rule, all appeals to the plan, plan administrator, claims administrator, or applicable vendor must be made, initiated in writing, within one hundred eighty (180) days of receiving the denial or notice which gave rights to the appeal.

**(3) Appeal Process for Medical and Pharmacy Determinations.**

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply.

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage once an individual has been covered under the plan, unless the individual, or a person seeking coverage on behalf of the individual, performs an act, practice, or omission that constitutes fraud, or unless such individual or person makes an intentional misrepresentation of material fact in connection with seeking coverage or any benefits under the plan.

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination.

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative.

4. External review. External review means a review of an adverse benefit determination (including a final internal adverse benefit determination) by the Missouri Department of Insurance, Financial Institutions and Professional Registration, Division of Consumer Affairs (DIFP) regarding covered medical and pharmacy benefits administered by plan vendors, UMR, Mercy Health Plans, or Express Scripts Inc., in accordance with state law and regulations promulgated by DIFP and made applicable to the plan by agreement and between the plan and DIFP pursuant to Technical Guidance from the U.S. Department of Health and Human Services dated September 23, 2010.

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law.

6. Final external review decision. A final external review decision means a determination rendered under the DIFP external review process at the conclusion of an external review.

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect;

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

C. The termination or discontinuance of coverage is effective retroactively at the request of the member in accordance with applicable provisions of this chapter regarding voluntary cancellation of coverage.

**(B) Internal Appeals.**

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review by DIFP.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level appeals shall be responded to in writing to the member within sixty (60) days for post-service claims and within thirty (30) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First level appeals must be submitted in writing to—

UMR Claims Appeal Unit  
PO Box 30546  
Salt Lake City, UT 84130-0546

(b) Second level appeals must be sent in writing to—

UMR Claims Appeal Unit  
PO Box 8086  
Wausau, WI 54402-8086

(c) Expedited appeals must be communicated by calling UMR telephone 1-866-868-7758 or by submitting a written fax to 1-866-912-8464, Attention: Appeals Unit.

(VI) For members with medical coverage through Mercy Health Plans—

(a) First and second level appeals must be submitted in writing to—

Mercy Health Plans  
Attn: Corporate Appeals  
14528 S. Outer 40 Road, Suite 300  
Chesterfield, MO 63017

(b) Expedited appeals must be communicated by calling Mercy Health Plans telephone 1-800-830-1918, ext. 2394 or by submitting a written fax to 1-314-214-3233, Attention: Corporate Appeals.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member claimant attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the claimant believes the claim should be paid, and any other written documentation to support the claimant's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts  
Clinical Appeals—MH3  
6625 West 78th Street, BL0390  
Bloomington, MN 55439  
or by fax to 1-877-852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(4) Except as otherwise expressly provided in this rule, appeals of adverse determinations made by MCHCP may be appealed to the board by fax or letter to the following address:

Attn: Appeal  
Board of Trustees  
Missouri Consolidated Health Care Plan  
PO Box 104355  
Jefferson City, MO 65110

/(6)/(5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines:/.

(A) Newborns—If a member currently has coverage under the plan, he/she may enroll his/her newborn retroactively to the date of

birth if the request is made within three (3) months of the child's date of birth.

(B) Agency error—MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office, the MCHCP, or plan offered by MCHCP that was no fault of the member.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year.

(D) Non-payment—MCHCP may allow one (1) reinstatement for terminations due to non-payment (per lifetime of account).

(E) Reinstatement before termination—MCHCP may reinstate coverage if request is received prior to end of current coverage.

(F) Termination dental and/or vision coverage—MCHCP may terminate dental and/or vision coverage if request is received prior to February 1 and if no claims have been made/paid for January.

(G) Proof of eligibility—MCHCP may approve late receipt of proof-of-eligibility documentation if MCHCP can verify that it took an unreasonable amount of time for the public entity (county or state) to provide subscriber with requested documentation.

(H) Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage.

(I) Loss of coverage notice—MCHCP may approve late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.

(J) *[Lifestyle Ladder] Wellness Program* participation—MCHCP may deny all appeals regarding continuation of participation in *[Lifestyle Ladder] the Wellness Program* due to failure of member's participation.

(K) Proof of open enrollment confirmation—MCHCP may approve appeals if subscriber is able to provide a confirmation sheet from open enrollment. However, such administrative appeals must be received by MCHCP on or before the last day of February.

(L) Substantiating evidence—MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period.

(M) New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Amended: Filed Dec. 22, 2008, effective June 30, 2009. Amended: Filed Feb. 17, 2010, effective Aug. 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, terminated Jan. 20, 2011. Emergency amendment filed Jan. 10, 2011, effective Jan. 20, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-3.090 Pharmacy Benefit Summary.** The Missouri Consolidated Health Care Plan is amending the rule purpose and sections (1) and (6), deleting section (3) and renumbering accordingly, and adding new sections (7) and (8).

**PURPOSE:** This amendment includes changes to the policy of the board of trustees in regard to the Pharmacy Benefit Summary for the PPO 600 Plan, PPO 1000 Plan, and PPO 2000 Plan of the Missouri Consolidated Health Care Plan.

**PURPOSE:** This rule establishes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for [Copay Plan, PPO 300 Plan, PPO 500 Plan,] **the PPO 600 Plan, PPO 1000 Plan, and PPO 2000 Plan of the Missouri Consolidated Health Care Plan.**

**EMERGENCY STATEMENT:** This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri and United States Constitutions** and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.

(1) The pharmacy benefit provides coverage for prescription drugs **listed on the formulary**, as described in the following:

(A) Medications.

1. **Retail—Network:**

A. Generic: Eight-dollar (\$8) copayment for up to a thirty (30)-day supply for generic drug on the formulary;

B. **[Formulary brand] Brand:** Thirty-five-dollar (\$35) copayment for up to a thirty (30)-day supply for brand drug on the formulary;

**[C. Non-formulary: Fifty-five dollar (\$55) copayment for up to a thirty (30)-day supply for non-formulary drug;**

D. **Prescriptions filled with a formulary brand drug when there is a Food and Drug Administration (FDA)-approved generic will be subject to the generic copayment amount in addition to paying the difference between the cost of the generic and the formulary brand drug;]**

**[E/C. Mail order program—**

(I) Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for **[two and one-half (2 ½) regular copayments] a twenty-dollar (\$20) copayment for a generic drug on the formulary or a eighty-seven-dollar-and-fifty-cent (\$87.50) copayment for a brand drug on the formulary.**

(II) Specialty drugs covered only through network mail order for up to thirty (30) days. Copayments:

(a) Generic: **[six] eight dollars [and sixty-seven cents (\$6.67);] (\$8) for generic drug on the formulary list; and**

**[(b) Formulary brand: twenty-nine dollars and seventeen cents (\$29.17); and**

**(c) Non-formulary: forty-five dollars and eighty-three cents (\$45.83).]**

**(b) Brand: thirty-five dollars (\$35) for brand drug on the formulary.**

2. **Non-network pharmacies—**If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable copayment **or coinsurance**. All such claims must be filed within twelve (12) months of the incurred expense.

3. **Retail prescription drugs—**Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

**[(3) Retail and mail order coverage includes the following (except for specialty drugs):**

**(A) Diabetic supplies, including:**

1. **Insulin;**
2. **Syringes;**
3. **Test strips;**
4. **Lancets; and**
5. **Glucometers;**

**(B) Prescribed vitamins, excluding those vitamins that may be purchased over-the-counter;**

**(C) Prescribed self-injectables;**

**(D) Oral chemotherapy agents;**

**(E) Hematopoietic stimulants;**

**(F) Growth hormones with prior authorization;**

**(G) Infertility drugs—subject to fifty percent (50%) member coinsurance; and**

**(H) Tobacco cessation prescriptions—subject to formulary restrictions and limited to five hundred dollar (\$500) annual benefit.]**

**[(4)](3) Step Therapy—**Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first step drug, the physician may request a prior authorization from the pharmacy plan administrator. If the prior authorization is approved, the member is responsible for the applicable copayment which may be higher than the first step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.

**(A) First Step—**

1. **Uses primarily generic drugs;**
2. **Lowest applicable copayment is charged; and**
3. **First step drugs must be used before the plan will authorize payment for second step drugs.**

**(B) Second Step—**

1. **This step applies if the member's treatment plan requires a different medication after attempting the first step medication;**
2. **Uses primarily brand-name drugs; and**
3. **Typically, a higher copayment amount is applicable.**

**[(5)](4) Prior Authorization—**Certain medications are subject to prior authorization. Network pharmacies will notify the member if prior authorization is required. The member or the pharmacy must contact the pharmacy plan administrator before payment will be approved.

[(6)](5) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy plan administrator. In order to file a claim, members must—

(A) Complete the claim form; and

(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions, except diabetic supplies. If attaching a receipt or label, the receipt or label shall include/—/:

1. Pharmacy name and address;
2. Patient's name;
3. Price;
4. Date filled;
5. Drug name, strength, and national drug code (NDC);
6. Prescription number;
7. Quantity; and
8. Days' supply.

[(7)](6) Formulary—The formulary *[does not change during a calendar year, unless]* is updated on a semi-annual basis, or when—

(A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; or

(B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit; *[and]* or

(C) A drug is determined to have a safety issue.

(7) Limitation—Prescription drugs not listed on the formulary are not a covered benefit except for prescription drugs that have been grandfathered for members who have taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011. If the participant purchased a brand-name drug that is grandfathered when there is a Food and Drug Administration (FDA)-approved generic drug, the participant shall pay the generic copayment plus the difference in the brand and generic cost of the drug. Grandfathered drugs include:

(A) Alzheimer's disease drugs;

(B) Antidepressants, including selective serotonin reuptake inhibitors (SSRIs) and selective serotonin and norepinephrine reuptake inhibitors (SNRIs);

(C) Anti-epileptics;

(D) Biologics for inflammatory conditions;

(E) Cancer drugs;

(F) Hemophilia drugs (Factor VIII and IX concentrates);

(G) Hepatitis drugs;

(H) Immunosuppressants (transplant anti-rejection agents);

(I) Insulin (basal);

(J) Low molecular weight heparins;

(K) Multiple sclerosis injectable drugs;

(L) Novel psychotropics (oral products and long-active injectables);

(M) Phosphate binders;

(N) Pulmonary hypertension drugs; and

(O) Somatostatin analogs.

(8) Under the High Deductible Health Plan (HDHP), pharmacy benefits are subject to the applicable medical plan deductible and coinsurance.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY RULE**

**22 CSR 10-3.092 Dental Benefit Summary**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the Dental Benefit Summary for members of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the Missouri Register. This emergency rule complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Two (2) dental benefit packages are available for a public entity to choose from—basic and high.

(A) The basic benefit package provides coverage for—

1. Coverage A—diagnostic and preventive services;
2. Coverage B—basic and restorative services; and
3. Coverage C—major services.

(B) The high benefit package provides coverage for—

1. Coverage A—diagnostic and preventive services;
2. Coverage B—basic and restorative services;
3. Coverage C—major services; and

4. Coverage D—orthodontic services for children younger than nineteen (19).

(2) Procedures for Using the Dental Plan. A member may visit the dentist of his/her choice and select any dentist on a treatment-by-treatment basis. Members may go to a participating or non-participating network dentist. If a member goes to a non-participating network dentist, the dental plan will make payment directly to the member on the lesser of the dentist billed charge or the applicable maximum plan allowance.

(3) Dental benefits, deductibles, and coinsurance include:

<b>DENTAL SERVICES</b>			
	<b>BASIC</b>	<b>HIGH</b>	
<b>Coverage A – Diagnostic &amp; Preventive</b>	<b>You Pay</b>	<b>You Pay</b>	<b>Note</b>
Examinations Prophylaxis (teeth cleaning) Fluoride X-rays Emergency Palliative Treatment Space Maintainers Sealants	No deductible 0% coinsurance	No deductible 0% coinsurance	Dental exams, X-rays, cleanings and fluoride treatment do not apply to the individual plan maximum
<b>Coverage B – Basic &amp; Restorative</b>	<b>You Pay</b>	<b>You Pay</b>	<b>Note</b>
Minor Restorative Services (fillings) Oral surgery, including extractions Periodontics Endodontics	\$50/person deductible* 20% coinsurance	\$50/person deductible* 20% coinsurance	
<b>Coverage C – Major Services</b>	<b>You Pay</b>	<b>You Pay</b>	<b>Note</b>
Prosthodontics (bridges, dentures) Major Restorative Services (crowns, inlays, onlays, labial veneers)	\$50/person deductible* 50% coinsurance	\$50/person deductible* 50% coinsurance	12-month waiting period applies to replacement prosthetic devices. The waiting period is waived with proof of 12-month continuous dental coverage for major services immediately prior to the effective date of coverage in MCHCP's dental plan
<b>Coverage D – Orthodontic Services for children younger than 19</b>	<b>You Pay</b>	<b>You Pay</b>	<b>Note</b>
Treatment for correction of malposed teeth to establish proper occlusion through movement of teeth or their maintenance in position	Orthodontia is not covered	\$50/child deductible* 50% coinsurance	Orthodontic lifetime maximum of \$1,000 per dependent child younger than 19
Coverage is limited to \$1,000 per person per calendar year benefit period. *Coinsurance amounts apply after the \$50 individual deductible is met under Coverage B, C or D, or combined.			



(4) Alternative Treatment. If alternative treatment plans are available, this dental plan will be liable for the least costly, professionally satisfactory course of treatment. This includes, but is not limited to, services such as composite resin fillings on molar teeth, in which case the benefits are based on the cost of the amalgam (silver) filling. This also includes fixed bridges, in which case the benefits will be based on the cost of a removable partial denture.

(5) Transferring Care. If participant receives care from more than one (1) dentist or service provider for the same procedure, benefits will not exceed what would have been paid for one (1) dentist for that procedure (including, but not limited to, prosthetic devices and root canal therapy).

(6) Claim Pre-Determination. If the care member needs costs less than two hundred dollars (\$200) or is emergency care, member's dentist will proceed with treatment at member's option. If the cost estimate is more than two hundred dollars (\$200) and is not emergency care, member's dentist will determine what treatment member needs and could submit a treatment plan to dental plan for a pre-determination of benefits. This estimate will enable the member to determine in advance how much of the cost will be paid by his/her dental coverage and how much he/she will be responsible for paying.

(7) Claim Filing Deadline. Member's claims must be filed by the end of the calendar year after the year in which services were rendered. The dental plan is not obligated to pay claims submitted after this period. If a claim is denied due to a participating dentist's failure to make timely submission, participant will not be liable to such dentist for the amount that would have been payable by the dental plan, provided that member advised the dentist of participant's eligibility for benefits at the time of treatment.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed rule covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY RULE**

**22 CSR 10-3.093 Vision Benefit Summary**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the vision benefit summary for members of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare.*

*This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the Missouri Register. This emergency rule complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Vision Plan. The vision benefit provides coverage of refractive care exams, eyeglass lenses and frames, contact lenses, and corrective laser surgeries.

(2) Vision benefits and copayments include:

VISION SERVICES		
BENEFITS	NETWORK	NON-NETWORK
<b>Exams – once every 12 months</b>		
<b>Vision Exam</b>	\$10 copayment	Reimbursed up to \$36
<b>Lenses – once every 12 months – one \$25 copayment for lenses and frames when purchased together</b>		
<b>Single vision lenses (per pair)</b>	\$25 copayment	Reimbursed up to \$28
<b>Bifocal lenses (per pair)</b>	\$25 copayment	Reimbursed up to \$45
<b>Trifocal lenses (per pair)</b>	\$25 copayment	Reimbursed up to \$56
<b>Lenticular lenses (per pair)</b>	\$25 copayment	Reimbursed up to \$80
<b>Polycarbonate lenses (per pair)</b> Applies to dependent children only	\$25 copayment	Not covered
<b>Frames – once every 24 months – one \$25 copayment for lenses and frames when purchased together</b>		
<b>Frames</b>	\$25 copayment Up to \$120 plus 20% discount on any out-of-pocket costs	Reimbursed up to \$45
<b>Contact Lenses – once every 12 months in place of eye glass lenses</b>		
<b>Elective</b> If member prefers contacts to glasses	\$10 copayment for exam Up to \$125 for contact lenses and contact lens exam (fitting and evaluation) 15% discount on the cost of contact lens exam (fitting and evaluation)	Reimbursed up to \$36 for exam Contact lenses, evaluation, design and fitting reimbursed up to \$105
<b>Necessary</b> If medically necessary with prior approval from VSP	\$10 copayment for exam Additional costs covered at 100%	Reimbursed up to \$36 for exam Contact lenses, evaluation, design and fitting reimbursed up to \$210
<b>Corrective Laser Surgery – contact your provider, or contact VSP at 888-354-4434 for more information</b>		

<b>PRK</b>	Maximum amount you pay: \$1,500 per eye	Not covered
<b>LASIK</b>	Maximum amount you pay: \$1,800 per eye	Not covered
<b>Custom LASIK</b>	Maximum amount you pay: \$2,300 per eye	Not covered
<b>Other</b>		
<b>Optional Items (cosmetic extras)</b>	Not covered	Not covered

(3) Value-Added Discount Program. A member can receive a twenty-percent (20%) discount on additional glasses and sunglasses, including lens options from any network provider, within twelve (12) months of participant's last eye exam.

(4) Soft Contact Lenses. A member who wears soft contact lenses will qualify for a special contact lens program. The program covers—

(A) A contact lens exam;

(B) Six (6)-month supply of contacts from the specific list of contact lens products and manufacturers; and

(C) Two (2) follow-up visits.

(D) A member who requires premium services when being fitted for contact lenses will not qualify for the contact lens care program. The member's provider will determine if the member qualifies for a standard fit or a premium fit based on the guidelines of—

1. Standard fit contact lens patients—

A. Typically the member does not require additional time for care, training, or problem solving; and

B. Typically the member can be successfully fitted in up to two (2) follow-up visits; and

2. Premium fit contact lens patients—

A. Typically the member will require additional time for care, training or problem solving; and

B. Typically the member cannot be successfully fitted in up to two (2) follow-up visits.

(E) The member will be responsible for the cost above the allowed network or non-network contact lens benefit. Contact lens care program products, manufacturers, replacement fees, and refit fees are as follows:

Tier One: Spherical				
Product	Manufacturer	Boxes Covered	Replacement Wearers	Refit Wearers
ACUVUE	Vistakon	4	\$130	\$170
ACUVUE 2	Vistakon	4		
AIR OPTIX AQUA	CIBA Vision	2		
Biofinity	CooperVision	2		
Biomedics 55 Premier	CooperVision	4		
Biomedics 55 UV	CooperVision	4		
Biomedics XC	CooperVision	4		
Focus Monthly Visitint (Focus Visitint)	CIBA Vision	2		
Frequency 38	CooperVision	2		
Frequency 55 Aspheric	CooperVision	2		
Frequency 55 Sphere	CooperVision	2		
FreshLook Handling Tint	CIBA Vision	4		
O2OPTIX	CIBA Vision	2		
Proclear Sphere (Compatibles)	CooperVision	2		
PureVision	Bausch & Lomb	2		
SofLens 39 (Optima FW, Seequence II)	Bausch & Lomb	4		
Vertex Sphere (Encore Sphere)	CooperVision	4		

Tier Two: Spherical				
Product	Manufacturer	Initial Supply Boxes	Replacement Wearers	Refit Wearers
ACUVUE ADVANCE	Vistakon	4	\$160	\$190
ACUVUE OASYS with HYDRACLEAR PLUS	Vistakon	4		
AIR OPTIX NIGHT & DAY AQUA	CIBA Vision	2		
Avaira	CooperVision	4		
Biomedics 38	CooperVision	4		
Extreme H <sub>2</sub> O 59% - Thin	Hydrogel	4		
Extreme H <sub>2</sub> O 59% - Xtra	Hydrogel	4		
Extreme H <sub>2</sub> O 54%	Hydrogel	4		
Focus 1-2 Week Visitint (NewVues Visitint)	CIBA Vision	4		
PRECISION UV	CIBA Vision	4		

<b>Tier Three: Specialty Lenses</b>				
<b>Product</b>	<b>Manufacturer</b>	<b>Initial Supply Boxes</b>	<b>Replacement Wearers</b>	<b>Refit Wearers</b>
<b>ACUVUE ADVANCE <i>for ASTIGMATISM</i></b>	<b>Vistakon</b>	<b>4</b>	<b>\$180</b>	<b>\$210</b>
<b>ACUVUE OASYS <i>for ASTIGMATISM</i></b>	<b>Vistakon</b>	<b>4</b>		
<b>AIR OPTIX <i>for ASTIGMATISM</i></b>	<b>CIBA Vision</b>	<b>2</b>		
<b>Biofinity Toric</b>	<b>CooperVision</b>	<b>2</b>		
<b>Focus Monthly Toric Visitint (Focus Toric)</b>	<b>CIBA Vision</b>	<b>2</b>		
<b>Frequency 55 Multifocal</b>	<b>CooperVision</b>	<b>2</b>		
<b>Frequency 55 Toric</b>	<b>CooperVision</b>	<b>2</b>		
<b>Proclear EP Multifocal</b>	<b>CooperVision</b>	<b>4</b>		
<b>PureVision Multifocal</b>	<b>Bausch &amp; Lomb</b>	<b>2</b>		
<b>PureVision Toric</b>	<b>Bausch &amp; Lomb</b>	<b>2</b>		
<b>SofLens Toric</b>	<b>Bausch &amp; Lomb</b>	<b>4</b>		

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed rule covering this same material is published in this issue of the Missouri Register.*

**T**he Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo Supp. 2010.

## EXECUTIVE ORDER 10-27

WHEREAS, I have been advised by the State Emergency Management Agency that on-going and forecast severe storm systems have caused, or have the potential to cause, damages associated with high winds and tornadoes impacting communities throughout the state of Missouri; and

WHEREAS, there have been at least three deaths associated with this storm system; and

WHEREAS, the severe weather that began on December 30, 2010, and is continuing, has created a condition of distress and hazard to the safety, welfare, and property of the citizens of the state of Missouri beyond the capabilities of some local jurisdictions, and other established agencies; and

WHEREAS, interruptions of public services are occurring, or anticipated to occur, as a result of the severe weather event that started on December 30, 2010, and is continuing; and

WHEREAS, the state will continue to be proactive where the health and safety of the citizens of Missouri are concerned; and

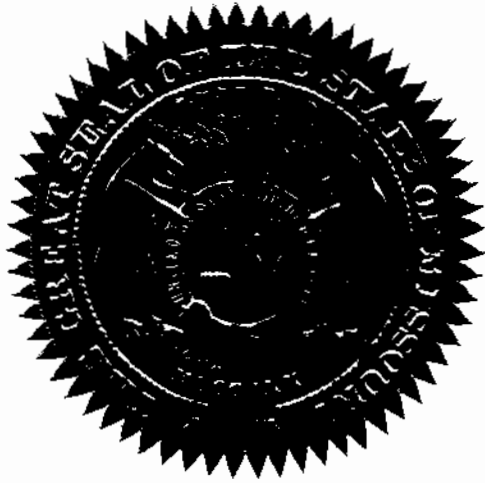
WHEREAS, the resources of the state of Missouri may be needed to assist affected jurisdictions and to help relieve the condition of distress and hazard to the safety and welfare of our fellow Missourians; and

WHEREAS, an invocation of the provisions of Sections 44.100 and 44.110, RSMo, will be required to ensure the protection of the safety and welfare of the citizens of Missouri.

NOW, THEREFORE, I, JEREMIAH W. (JAY) NIXON, Governor of the State of Missouri, by virtue of the authority vested in me by the Constitution and Laws of the state of Missouri, including Sections 44.100 and 44.110, RSMo, do hereby declare that a State of Emergency exists in the state of Missouri. I do hereby direct that the Missouri State Emergency Operations Plan be activated.

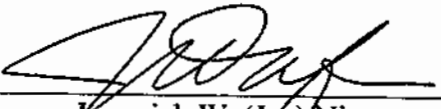
I further authorize the use of state agencies to provide assistance, as needed.


This order shall terminate on January 31, 2011, unless extended in whole or in part.



ATTEST:

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 31<sup>st</sup> day of December, 2010.

  
Jeremiah W. (Jay) Nixon  
Governor

  
Robin Carnahan  
Secretary of State

**U**nder this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

**E**ntirely new rules are printed without any special symbolology under the heading of the proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

**A**n important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment, or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

**I**f an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register*. If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

**A**n agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety (90)-day-count necessary for the filing of the order of rulemaking.

**I**f an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

(2) The commissioner of administration shall maintain the cafeteria plan, the dependent care assistance plan, and the flexible medical benefits plan, in written form, denominated as the Missouri State Employees' Cafeteria Plan [(Appendix A), the Missouri State Employees' Dependent Care Assistance Plan (Appendix B) and the Missouri State Employees' Flexible Medical Benefits Plan (Appendix C), which are included herein, for Plan Year 1998 and years following] **Document attached as Appendix A.**

Proposed Amendment Text Reminder:

**Boldface text indicates new matter.**

*[Bracketed text indicates matter being deleted.]*

## **Title 1—OFFICE OF ADMINISTRATION Division 10—Commissioner of Administration Chapter 15—Cafeteria Plan**

### **PROPOSED AMENDMENT**

**1 CSR 10-15.010 Cafeteria Plan.** The commissioner is amending Section (2) and deleting Appendices A, B, and C and replacing with Appendix A Cafeteria Plan for the Employees of the State of Missouri Plan Document.

*PURPOSE: This amendment is being filed to comply with federal regulations of Section 125 of the IRS Code.*

*PURPOSE: This rule complies with the statutory requirement that the commissioner file a written plan document in accordance with Chapter 536, RSMo, and payroll deduction qualifications in accordance with Chapter 33, RSMo.*



[APPENDIX A  
MISSOURI STATE EMPLOYEES' CAFETERIA PLAN

*The State of Missouri through the Office of Administration hereby amends and restates the Missouri State Employees' Cafeteria Plan (hereinafter called the MSEC) effective January 1, 2009. The provisions of the MSEC, as set forth in this document and the attendant documents for the Missouri State Employees' Dependent Care Assistance Plan (Appendix B, hereinafter called the MSEDCA) and the Missouri State Employees' Flexible Medical Benefits Plan (Appendix C, hereinafter called the MEFMBP), shall be applicable to each employee of the State of Missouri unless he/she elects not to participate in the MSEC beginning with Plan Year 2009.*

ARTICLE ONE  
DEFINITIONS

1.01 "Account" means the account(s) maintained under the MSEC by the Plan Administrator to which allocations of employer contributions are made for each participant as required by the MSEC and from which payments, as permitted by the MSEC, shall be paid.

1.02 "Employee" means any person employed by the employer.

1.03 "Employer" means the State of Missouri including any agency, or department of the State of Missouri other than the University of Missouri and Southeast Missouri State University.

1.04 "Office of Administration" means the Office of Administration of the State of Missouri.

1.05 "Participant" means any employee who has not waived coverage and is participating in the MSEC.

1.06 "Plan Administrator" means the Office of Administration or its duly appointed designee to administer the MSEC.

1.07 "Plan Year" means the calendar year.

1.08 "Spouse or Dependent" means the spouse or dependent of a participant within the meaning of Section 125 and 152 of the Internal Revenue Code.

1.09 "FMLA" means the Family and Medical Leave Act of 1993, as amended.

1.10 "Waive coverage" means to formally opt-out of participation in the MSEC sections 4.01(a), 4.01(b), 4.01(c), 4.01(d), 4.01(e), and/or 4.01(g) in writing or online.

ARTICLE TWO  
STATEMENT OF PURPOSE

2.01 This Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code, as amended, and is to be interpreted in a manner consistent with the requirements of Section 125. The purpose of the MSEC is to provide to participants the tax savings opportunities permissible under Section 125 of the Internal Revenue Code.

2.02 The MSEC will be nondiscriminatory, as such term is used in Section 125 of the Internal Revenue Code, and the employer will take such action as may be necessary to maintain the MSEC as nondiscriminatory under said code section.

ARTICLE THREE  
ELIGIBILITY AND PARTICIPATION

3.01 The MSEC does not apply to any individual who terminated employment with the employer prior to the effective date of this amended and restated MSEC (January 1, 2009) unless such individual becomes reemployed by the employer on or after such effective date.

3.02 Any employee who is on the payroll of the employer as of the effective date is eligible to become a participant on the effective date. Any employee, except any employee subject to the provisions of the MSEC, section 3.03, who chooses not to become a participant at the beginning of each Plan Year will not again become eligible for participation in the MSEC until the beginning of the next Plan Year, except as provided under the MSEC, section 3.09.

3.03 Any person who becomes an employee after the effective date shall be automatically enrolled unless waiving coverage in the MSEC within thirty-one (31) days from the date of employment. Such employee shall become a participant on the first day of the first full month coincident with or next following the date of employment.

3.04 Subject to the provisions of the MSEC, section 3.05, an eligible employee shall automatically become a participant of 4.01(a), 4.01(d), 4.01(e), and 4.01(g) for any and each Plan Year unless waiving coverage of the specific plan, and agree to and authorize the reduction of the participant's compensation by a permissible amount for credit to the participant's account as maintained by the Plan Administrator. For purposes of the first sentence of this paragraph, the term "permissible amount"

(unless and until subsequently changed by appropriate action of the Office of Administration and notice of such change is provided to all participants) means an amount(s) determined by the participant which is (are):

(a) not more than the expected total cost or premium during the Plan Year in the case of the State-Sponsored Medical Insurance benefit described in the MSEC, section 4.01(a);

(b) not more than five thousand dollars (\$5,000) in the case of the Flexible Medical Benefits benefit described in the MSEC, section 4.01(b);

(c) not more than five thousand dollars (\$5,000) in the case of the Dependent Care Assistance benefit described in the MSEC, section 4.01(c);

(d) not more than the expected total cost or premium during the Plan Year in the case of the State-Sponsored Dental Insurance benefit described in the MSEC, section 4.01(d);

(e) not more than the expected total cost or premium during the Plan Year in the case of the State-Sponsored Vision Care Insurance benefit described in the MSEC, section 4.01(e).

(f) not more than the expected sum of the total cost or premium during the Plan Year in the case of any other product or products eligible under Section 125 of Title 26 of the United States Code, as described in MSEC section 4.01(g).

In the event of any change in the permissible amount, the resulting new permissible amount must be nondiscriminatory (as defined in Section 125 of the Internal Revenue Code) in its application to participants. In the case of the insurance benefits or products described in the MSEC, sections 4.01(a), 4.01(d), 4.01(e), and 4.01(g) the permissible amount must be consistent with the actual rate in effect at the start of the coverage period or it will automatically be changed to reflect the actual rate in effect at the start of the coverage period.

3.05 Except as otherwise provided in the MSEC, section 3.03, the waiving of elections and flexible benefit authorizations required by the provision of the MSEC section 3.04 must be submitted to the Plan Administrator by a date established by the Plan Administrator which shall be prior to the first day of the applicable Plan Year. Any employee who becomes a participant pursuant to the MSEC, section 3.03 shall be allowed to submit the required waiver request with the Plan Administrator no later than thirty-one (31) days from the date of employment in order to waive participation from the program.

3.06 Any employee who fails to make an election when first eligible under section 3.04 or 3.05 shall be deemed to have elected to reduce his or her cash compensation in an amount equal to the total of the amounts for coverage in effect on the first day of participation of the applicable Plan Year described in sections 4.01(a), 4.01(d), 4.01(e), and 4.01(g) and to have such amounts pay for coverage described in sections 4.01(a), 4.01(d), 4.01(e), and 4.01(g) to the extent he or she has elected such coverage. Further, any such employee who fails to make an election under section 3.04 or 3.05 shall be deemed to have elected to not receive any benefits under the coverage described in sections 4.01(b) and 4.01(c) and to receive the balance of his or her entire compensation in cash.

3.07 Any employee duly enrolled and participating in one or more of the insurance plans described in the MSEC, sections 4.01(a), 4.01(d), 4.01(e), or 4.01(g) shall be considered to have submitted the required authorization to continue participation in the same plan(s) for the subsequent Plan Year at an amount equal to the total expected annual cost or premium based on the rate in effect as of January 1 of that subsequent Plan Year. A participant who does not wish to continue an insurance plan under the Cafeteria Plan for a subsequent Plan Year must so specify on the appropriate election form or in an alternate prescribed manner prior to the start of the subsequent Plan Year.

3.08 Any employee who elects pursuant to an authorization under section 3.05 of this Plan an amount under the Flexible Medical Benefits described in the MSEC, section 4.01(b) or the Dependent Care Assistance plan described in the MSEC, section 4.01(c) for any Plan Year shall be deemed to have also made an election to receive benefits under sections 4.01(a), 4.01(d), 4.01(e), and 4.01(g) to the extent the participant's share of premiums (if any) for any benefits under sections 4.01(a), 4.01(d), 4.01(e), and 4.01(g).

### 3.09 Permitted Election Changes.

(a) Following the commencement of any Plan Year for which an employee participates in the MSEC, the authorization filed with the Plan Administrator for such Plan Year may neither be changed nor revoked except as provided in this section. An employee may revoke an election during a period of coverage and make a new election for the remainder of the relevant coverage period only as provided in paragraphs (b) through (h) of this section. Such revocation and new election must be made within sixty (60) days of an event described in (b) through (g) of this section and is made on account of and corresponds to the event.

(b) Special enrollment rights. An employee may revoke an election for a benefit described under Article Four, section 4.01(a), 4.01(d), or 4.01(e) and make a new election that corresponds with the special enrollment rights provided in Internal Revenue Code Section 9801(f) (HIPAA), whether or not the change in election is permitted under paragraph (c) of this section.

(c) Changes in status.

1. An employee may revoke an election and make a new election for the remaining portion of the period if, under the facts and circumstances—

(i) A change in status occurs; and

(ii) The election change satisfies the consistency requirement in paragraph (c)(3) of this section.

2. Change in status events. The following events are changes in status for purposes of this paragraph (c)—

(i) Legal marital status. Events that change an employee's legal marital status, including marriage, death of spouse, divorce, legal separation, or annulment;

(ii) *Number of dependents.* Events that change an employee's number of dependents (as defined in Internal Revenue Code Section 152), including birth, adoption, placement for adoption (as defined in regulations under Internal Revenue Code Section 9801), or death of a dependent, or in the case of Dependent Care, a change in the number of qualifying individuals as defined in the Internal Revenue Code Section 21(b)(1);

(iii) *Employment status.* Any of the following events that change the employment status of the employee, spouse, or dependent is considered a change in status. A termination, commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence of more than thirty (30) days, change in worksite, or any other employment status change that affects eligibility under this plan or employee benefit plan of the employer of the spouse or dependent;

(iv) *Dependent satisfies or ceases to satisfy the requirements for unmarried dependents.* An event that causes an employee's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstances as provided in the accident or health plan under which the employee receives coverage; and

(v) *Residence.* A change in the place of residence of the employee, spouse, or dependent.

3. *Consistency rule—*

(i) *General rule.* An employee's revocation of a Cafeteria Plan election during a period of coverage and a new election for the remaining portion of the period (referred to as an "election change") is consistent with a change in status if, and only if—

(A) The change in status results in the employee, spouse, or dependent gaining or losing eligibility for coverage under either the Cafeteria Plan or a plan of the spouse's or dependent's employer; and

(B) The election change corresponds with that gain or loss of coverage.

(ii) If the change in status is the employee's divorce, annulment or legal separation from a spouse, the death of a spouse or dependent, or a dependent ceasing to satisfy the eligibility requirements for coverage, an employee's election under the cafeteria plan to cancel accident or health insurance coverage for any individual other than the spouse involved in the divorce, annulment, or legal separation, the deceased spouse or dependent, or the dependent that ceased to satisfy the eligibility requirements for coverage, respectively, fails to correspond with that change in status. Thus, if a dependent dies or ceases to satisfy the eligibility requirements for coverage, the employee's election to cancel accident or health coverage for any other dependent, for the employee, or for the employee's spouse fails to correspond with that change in status.

In addition, if an employee, spouse, or dependent gains eligibility for coverage under a plan provided by the employer of the spouse or dependent as a result of a change in marital status or a change in employment status, the employee may cease or decrease coverage for that individual only if coverage for that individual becomes applicable or is increased under that employer's plan.

(iii) A change in status results in an employee, spouse, or dependent gaining (or losing) eligibility for coverage under a plan only if the individual becomes eligible (or ineligible) to participate in the plan. An individual is considered to gain or lose eligibility for coverage if the individual becomes eligible (or ineligible) for a particular package option under a plan (e.g., a change in status results in an individual becoming eligible for a managed care option or an indemnity option). If, as a result of a change in status, the individual gains eligibility for elective coverage under a plan of the spouse's or dependent's employer, the consistency rule of this paragraph (c)(3)(i) is satisfied only if the individual elects the coverage under the spouse's or dependent's employer.

(iv) *Exception for COBRA.* Notwithstanding paragraph (c)(3)(i) of this section, if the employee, spouse, or dependent becomes eligible for continuation coverage under any of the employer's health plans described in sections 4.01(a), 4.01(d), 4.01(e), or 4.01(g) as provided under COBRA or any similar state law, the employee may increase payments under the Cafeteria Plan in order to pay for the continuation coverage.

(v) Except as provided in this paragraph the provisions of paragraph (c) apply to an election change under a benefit described under Article 4.01(b). A participant may reduce an election for a benefit described under 4.01(b) due to a change in status if and only if the employee's legal marital status changes due to death, divorce, annulment, or legal separation, or there is a reduction in the number of dependents of the employee (as defined in section 152 of the Internal Revenue Code) due to death.

(d) *Judgment, decree, or order.* This paragraph (d) applies to a judgment, decree, or order ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in section 609 of the Employee Retirement Income Security Act of 1974) that requires accident or health coverage for an employee's child. Notwithstanding the provisions of paragraph (c) of this section, an employee may—

1. Make an election change to a plan described under sections 4.01(a), 4.01(b), 4.01(d), 4.01(e), or 4.01(g) to provide coverage for the child if the order requires coverage under the employee's plan; or

2. Make an election change to a plan described under sections 4.01(a), 4.01(b), 4.01(d), 4.01(e), or 4.01(g) to cancel coverage for the child if the order requires the former spouse to provide coverage.

(e) *Entitlement to Medicare or Medicaid.* If an employee, spouse, or dependent becomes entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), an employee may make an election change to a plan described under sections 4.01(a), 4.01(d), 4.01(e), or 4.01(g) to cancel coverage of that employee, spouse, or dependent under the accident or health plan. In addition, if an employee, spouse, or dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, an employee may make an election change to commence or increase coverage under a plan described under sections 4.01(a), 4.01(d), 4.01(e), or 4.01(g).

(f) *Coverage or cost changes.* Changes allowed under this section are not applicable to Flexible Medical Benefits as described in section 4.01(b). Therefore, no changes to an election for Flexible Medical Benefits is allowed due to events described in this section (f).

1. *Cost changes.* A participant's plan described under Article 4.01(a), 4.01(d), 4.01(e), or 4.01(g) will automatically be changed to reflect a change in the cost of coverage. Alternatively, if the premium amount significantly increases a participant may revoke an election and, in lieu thereof, to receive on a prospective basis, coverage under another health plan with similar coverage.

2. *Coverage changes.* If the coverage under a plan is significantly curtailed or ceases during a period of coverage, affected employees may revoke his/her election under the plan and may make a new election on a prospective basis for coverage under another plan option providing similar coverage. Coverage under an accident or health plan is significantly curtailed only if there is an overall reduction in coverage provided to participants under the plan so as to constitute reduced coverage to participants generally. For example, the loss of a participant's primary care physician would not be a significant curtailment because it does not affect participants in general.

*Addition (or elimination) of a plan option providing similar coverage.* If during a period of coverage the plan adds a new plan option or other coverage option (or eliminates an existing plan option or other coverage option) affected employees may elect the newly-added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other plan options providing similar coverage.

3. *Change in coverage of spouse or dependent under other employer's plan.* An employee may make a prospective election change to a plan described under sections 4.01(a), 4.01(d), 4.01(e), or 4.01(g) that is on account of and corresponds with an election made under the plan of the spouse's, former spouse's or dependent's employer if the period of coverage under the cafeteria plan or qualified plan of the spouse's, former spouse's, or dependent's employer only allows elections for periods of coverage different than the Plan Year for the MSEC.

(g) *Special requirements concerning the Family and Medical Leave Act.*

An employee taking FMLA leave may revoke an existing election for the remaining portion of the coverage period. Upon returning from FMLA leave, an employee may choose to be reinstated in any benefit described under this plan if such coverage was terminated during the FMLA leave (either by revocation or nonpayment of premiums). Such reinstatement will be on the same terms as prior to taking FMLA leave. However, the employee has no greater right to benefits for the remainder of the Plan Year than an employee who has been continuously working during the Plan Year. In addition to the rights granted under FMLA, such an employee has the right to revoke or change elections under the same terms and conditions as are available to employees participating in the Cafeteria Plan who are not on FMLA leave.

If an employee's coverage under a benefit described in section 4.01(b) or 4.01(c) terminates while the employee is on FMLA leave, the employee is not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. If that employee subsequently elects to be reinstated in a benefit previously terminated upon return from FMLA leave for the remainder of the Plan Year, the employee may not retroactively elect coverage for claims incurred during the period when the coverage was terminated. Further, the employee is not entitled to greater benefits relative to premiums paid than an employee who has been continuously working during the Plan Year. Therefore, if an employee elects to be reinstated in a benefit described above upon return from FMLA leave, the employee's coverage for the remainder of the Plan Year is equal to the employee's election for the 12-month period of coverage (or such shorter period as provided under section 3.03 or this section 3.09), prorated for the period during the FMLA leave for which no premiums were paid, and reduced by prior reimbursements.

(h) *Effective date of election changes.*

Any increase in the election amount designated by a participant made due to a change in status may include only those expenses which the participant expects to incur at a time during the period of coverage subsequent to the effective date of the increase. Any increase or decrease to an election amount for a program described in the Plan document under Article Four, section 4.01(b) or 4.01(c) shall be effective with the first day of the month coincident with or next following the Plan Administrator's receipt and approval of written notification of the new election. Any increase or decrease to an election amount for a program described in the Plan document under Article Four, section 4.01(a), 4.01(d), 4.01(e), or 4.01(g) shall be effective with the first required premium payment after the event.

3.10 If participation terminates due to a separation of service and the individual returns to eligible employment within thirty (30) days in the same Plan Year, then the participant's election will be reinstated as it was immediately prior to the separation of service. If participation terminates due to a separation of service and the individual returns to eligible employment after thirty (30) days in the same Plan Year, then the participant may make a new election for the remainder of the Plan Year. If salary reduction contributions were not made during the separation of service, the participant will not be able to be reimbursed for expenses incurred under benefits described under sections 4.01(b) and 4.01(c) during the separation.

3.11 A claim that is determined to be fraudulent by the plan administrator shall be denied. The administrator shall refer any fraud to the Office of Administration which will forward the matter to the employee's department and appropriate law enforcement for further action. The employee making a fraudulent claim shall be barred from future participation in the plan.

#### ARTICLE FOUR AVAILABLE SELECTION OF PLAN CATEGORIES

4.01 In general, employees are automatically enrolled into 4.01(a), 4.01(d), 4.01(e), and 4.01(g) unless waiving coverage in writing and may choose to participate in 4.01(b) and 4.01(c) offered under the MSEC:

(a) *State-Sponsored Medical Insurance*—This category provides for the direct payment to the insurance provider of the participant's share of the cost or premium for coverage under any plan or program which provides medical benefits or health insurance to or on behalf of any employee or spouse or dependent in the event of illness or personal injury to the employee or spouse or dependent, which plan or program is available to the employee by reason of status as an employee. The term plan or program, for purposes of this article, shall include any group insurance or other plan which is either provided by the

*Missouri Consolidated Health Care Plan (MCHCP), Missouri Department of Transportation and Missouri State Highway Patrol Medical & Life Insurance Plan, or Conservation Employees Benefits Plan Trust Fund, or is obtained by competitive bid and is not duplicative of any other plan provided by the State of Missouri. This article shall expressly include any Health Maintenance Organization (HMO) to which the employer makes a contribution on behalf of a participant;*

*(b) Flexible Medical Benefits—This category provides for payment to the participant of the cost of medical care for the participant or spouse or dependents of the participant. Such expenses must be incurred pursuant to the terms of the separate but related MSEFMBP (Appendix C), established in conjunction with the MSEC;*

*(c) Dependent Care Assistance—This category provides for payment to the participant of employment-related expenses for the care of the spouse or dependents of the participant. Such expenses must be incurred pursuant to the terms of the separate but related MSEDCA (Appendix B) established concurrently with the MSEC;*

*(d) State-Sponsored Dental Insurance—This category provides for the direct payment to the insurance provider of the participant's share of the cost or premium for coverage under any plan or program which provides dental benefits or dental insurance to or on behalf of any employee or spouse or dependent, which plan or program is available to the employee by reason of status as an employee. The term plan or program, for purposes of this article, shall include any group insurance or other plan which is either provided by the Missouri Consolidated Health Care Plan (MCHCP), or is obtained by competitive bid;*

*(e) State-Sponsored Vision Care Insurance—This category provides for the direct payment to the insurance provider of the participant's share of the cost or premium for coverage under any plan or program which provides vision care benefits or vision care insurance to or on behalf of any employee or spouse or dependent, which plan or program is available to the employee by reason of status as an employee. The term plan or program, for purposes of this article, shall include any group insurance or other plan which is either provided by the Missouri Consolidated Health Care Plan (MCHCP), or is obtained by competitive bid;*

*(f) Cash; and*

*(g) Other Products—This category provides for the direct payment to the insurance provider of the participant's share of the cost or premium for coverage under any qualified plan or program which provides any other qualified product eligible under Section 125 of the United States Code, to or on behalf of any employee or spouse or dependent, which plan or program is available to the employee through a payroll deduction agreement with the vendor.*

#### ARTICLE FIVE GENERAL PROVISIONS REGARDING PLANS

*5.01 No expenditure of any nature shall qualify for payment or reimbursement under the MSEC unless the expense is for the participant, the participant's spouse, or the participant's dependent. Such expenses must be incurred during the participant's period of coverage and must be related to the particular plan selection made by the participant at the time of enrollment for the period of coverage. For purposes of the MSEC, a period of coverage is any Plan Year (including an initial short Plan Year) or, in the case of participants subject to the MSEC, section 3.03, a period of coverage extends from the first day of the month coincident with or next following the hire date through the end of the Plan Year unless waiving coverage of the plan. In the case of medical expenses, an expense will be considered as having been incurred at the time the medical care related to the expense is provided and not at the time the expense is charged, billed or paid. Similarly, in the case of dependent care expenses, an expense will be considered as having been incurred at the time the dependent care related to the expense is provided.*

*5.02 Within forty-five (45) days following the end of each Plan Year, the Plan Administrator shall provide to each person who was a participant in the MSEFMBP or the MSEDCA at any time during the Plan Year an accounting statement reflecting contributions to and distributions from each account established for the participant during the Plan Year, including such other information as may be required by regulations promulgated by the Secretary of the Treasury or his/her delegate.*

#### ARTICLE SIX CONTRIBUTIONS TO PARTICIPANT ACCOUNTS

*6.01 Except as provided in the MSEFMBP, section 6.03 or Article VII, contributions to the account of each participant shall be made only by the employer and shall be made as follows: On the participant's regular pay date during each Plan Year, the employer shall cause to be contributed for credit to the account of said participant an amount equal to the sum of the permissible amounts elected by the participant for all plans selected for the Plan Year divided by the number of the participant's regular pay dates in the Plan Year subsequent to the participant's effective date of participation.*

*6.02 Any funds remaining to the credit of a participant's account as of the close of business on December 31 of a Plan Year shall be forfeited and revert to the employer; provided, however, that all such funds shall be held for a period of not less than ninety (90) days following the end of the Plan Year and be applied to the payment or reimbursement of covered expenses that the participant incurred during the Plan Year that the funds were credited and to the extent that claims for payment or reimbursement, accompanied by appropriate evidence of the related expenditures or obligations, are submitted to the Plan Administrator within the required period following the end of the Plan Year.*

#### ARTICLE SEVEN ADMINISTRATION

*7.01 Neither the employer nor the Plan Administrator makes any assurance to any participant that participation in the MSEC (or the related MSEDCA or MSEFMBP) is appropriate for any participant nor guarantees any loss which may result because of any participant's participation in the MSEC.*

7.02 The Plan Administrator shall make all determinations required respecting administration of the MSECP, including determinations as to the right of any person to a plan under the MSECP. Such determinations are final as approved by the Plan Administrator.

7.03 Any decision by the Plan Administrator regarding a denial of a claim for benefits or a change of election by a participant shall be stated in writing by the Plan Administrator and be delivered to the participant within thirty (30) days of the receipt by the Plan Administrator of the claim or change request; such notice shall set forth the specific reason for any denial. Any participant may file a written request with the Plan Administrator for a review of the denied claim for benefits or change of election within sixty (60) days of the notice of the denial. The Plan Administrator will notify the participant of its decision in writing within sixty (60) days of the request for review.

7.04 The Plan Administrator shall exercise a reasonable level of authority and responsibility in order to comply with the terms of the MSECP relating to the records of participants and amounts payable under the MSECP.

7.05 The Plan Administrator shall construe and interpret the MSECP, decide all questions of eligibility and determine the amount, manner and time of payment of any benefits hereunder.

7.06 Premium amounts returned by a medical or insurance provider or any benefit amount erroneously withheld and returned to the State by the Plan Administrator shall be deposited into the MSECP account. Allowable refunds, less required federal, state and Social Security tax withholdings, shall be issued by check payable to the participant from the MSECP account and wage reporting for tax purposes will be corrected.

7.07 Vendors of products included in 4.01(g) must comply with 1 CSR 10-4.010 and 1 CSR 10-15.010, and also agree to fees for the cost of administration, set by the Commissioner of Administration.

#### ARTICLE EIGHT MISCELLANEOUS

8.01 No participant shall have any right to or interest in any assets of the MSECP upon termination or otherwise except as provided under the MSECP, and then only to the extent of the benefits payable under the MSECP to such participant. All payments of benefits provided under the MSECP shall be made solely out of the assets of the employer.

8.02 Benefits payable under the MSECP shall not be subject to, in any manner, voluntary anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind.

8.03 Products included under 4.01(g) are not endorsed or provided by the State of Missouri. Solicitation by a vendor of signed employee applications or memberships may not be performed in State facilities at any time with the exception of qualified vendor products for the cafeteria plan and regulations under 1 CSR 10-15.010(3).

#### ARTICLE NINE AMENDMENTS AND TERMINATION

9.01 The employer reserves the right to make amendments to the MSECP at any time. Any amendment to the MSECP may be made with retroactive effect if determined to be necessary or desirable to comply with any applicable law or applicable regulation.

9.02 The employer may terminate the MSECP at any time.

9.03 Upon the expiration or termination of a Plan Year, the accounts of all participants affected thereby shall continue to be held by the Plan Administrator for distribution in accordance with the purposes and relevant provisions of the MSECP. If not so distributed within one hundred twenty (120) days following the last day of the expired or terminated Plan Year, balances shall thereupon be forfeited and revert to the employer.

#### APPENDIX B MISSOURI STATE EMPLOYEES' DEPENDENT CARE ASSISTANCE PLAN

The State of Missouri hereby establishes for the benefit of its employees a Dependent Care Assistance Plan (hereinafter called the MSEDCA) intended to conform to the requirements of paragraphs (2) through (8) of subsection (d) of Section 129 of the Internal Revenue Code, and in association with the Missouri State Employees' Cafeteria Plan, (Appendix A; hereinafter called the MSECP), established concurrently herewith.

#### ARTICLE ONE DEFINITIONS

1.01 "Dependent Care Assistance" means the direct payment to the participant or reimbursement to the participant for the payment of those services which are considered employment related expenses under Section 21(b)(2) of the Internal Revenue Code (relating to expenses for household and dependent care services necessary for gainful employment).

1.02 "Incurred" means when the participant is provided with the dependent care service that gives rise to the expense, and not when the participant is formally billed, charged for, or pays for the dependent care.

1.03 All terms defined in the related MSECP document, wherever used in this MSED CAP document, shall have the same meaning as required by the definition set forth in said MSECP document.

ARTICLE TWO  
STATEMENT OF PURPOSE

2.01 The purpose of this MSED CAP is to make possible the inclusion of Dependent Care Assistance in the group of benefits which may be selected by participants of the related MSECP and to satisfy the requirement of a separate written plan for a dependent care assistance program as set forth in Section 129(d)(1) of the Internal Revenue Code.

ARTICLE THREE  
ELIGIBILITY

3.01 Any person who is eligible to participate in the related MSECP is eligible to select Dependent Care Assistance as an optional benefit under the MSECP subject, however, to all terms, provisions and conditions set forth herein. The establishment of this MSED CAP in the form of a separate document is not intended, nor shall it be so interpreted or construed, as expanding or enlarging the rights or privileges of any participant for payment or reimbursement above the amount set forth in the related MSECP.

ARTICLE FOUR  
LIMITATIONS AND RESTRICTIONS ON PAYMENTS FROM THE PLAN

4.01 No direct payment to a participant or reimbursement to a participant for Dependent Care Assistance may be made from the MSED CAP unless the total assistance amount, including all other amounts paid to the participant for Dependent Care Assistance during the same Plan Year, does not exceed the lesser of: (a) five thousand dollars (\$5,000) (twenty-five hundred dollars (\$2,500) in the case of a married individual filing a separate return), or (b) the wages, salaries and other employee compensation of the participant if unmarried or if the participant is married does not exceed the lesser of such employee compensation of the participant or that of the participant's spouse. For purposes of this paragraph, employee compensation shall not include the total of the permissible amounts selected under the related MSECP. For each month during which a spouse is a full-time student or incapable of independent self-care, said spouse shall be deemed to be gainfully employed and to have employee compensation of two hundred fifty dollars (\$250) if there is only one (1) child or dependent and five hundred dollars (\$500) if there are two (2) or more children or dependents. A spouse is a student only if during each of five (5) calendar months during the Plan year said spouse is a full-time student at an education organization described in Internal Revenue Code Section 170(b)(1)(A)(iii).

4.02 No payment shall be made from the MSED CAP, directly or indirectly, for an obligation incurred by a participant during a Plan Year for services provided to the participant by a person who, under Internal Revenue Code Section 151(c), is allowable to the participant or the participant's spouse as a deduction for a personal exemption for the Plan Year, or who is a son, stepson, daughter or stepdaughter of the participant and is under age nineteen (19) at the close of the relevant Plan Year.

4.03 No direct payment to a participant or reimbursement to a participant for Dependent Care Assistance may be made from the MSED CAP in excess of the available funds in the individual participant's account. No reimbursements for any Plan Year will be made prior to February 1 of that Plan Year.

4.04 Claims for payment or reimbursement must be accompanied by invoices or such other reasonable evidence of expenditure as may be satisfactory to the Plan Administrator. Such evidence must include a written statement from an independent third party stating the date that the expense was incurred and the amount of such expense along with a signed statement from the participant that the expense has not been reimbursed and will not be reimbursed from any other source.

ARTICLE FIVE  
MISCELLANEOUS

5.01 Reasonable notification of the availability and terms of the MSED CAP and the related MSECP shall be provided by the employer to all employees.

5.02 On or before each January 31, the employer shall furnish to each participant under the MSED CAP a statement (form W-2) showing the total amount redirected under the Plan for payment of dependent care expenses incurred by the participant during the previous calendar year.

ARTICLE SIX  
AMENDMENT AND TERMINATION

6.01 The employer reserves to itself the right to amend this MSED CAP in any manner which it deems to be necessary or desirable and shall amend the MSED CAP in any respect necessary to conform the same to the provisions of the Internal Revenue Code or relevant regulations promulgated thereunder, and further reserves the right to terminate the MSED CAP by appropriate action.

APPENDIX C  
MISSOURI STATE EMPLOYEES' FLEXIBLE MEDICAL BENEFITS PLAN

*The State of Missouri hereby establishes for the benefit of its employees a Flexible Medical Benefits Plan (hereinafter called the MSEFMBP) intended to conform to the requirements of Section 105(b) of the Internal Revenue Code and in association with the Missouri State Employees' Cafeteria Plan (Appendix A, hereinafter called the MSEC), established concurrently herewith.*

ARTICLE ONE  
DEFINITIONS

*1.01 "Medical care expense" means expenses incurred by a participant, spouse or dependent for medical care to the extent that the participant or other person incurring the expense is not reimbursed for the expense through any other accident or health plan, as defined in United States Code Section 213(d). Expenses for premiums or contributions made to any other health or accident plan (whether or not maintained by the employer) and long-term care expenses are not considered Medical Care Expenses for the purposes of this Plan.*

*1.02 "Incurred" means when the participant is provided with the medical care that gives rise to the expense, and not when the participant is formally billed, charged for, or pays for the medical care.*

*1.03 All terms defined in the related MSEC document, whenever used in this MSEFMBP document, shall have the same meaning as required by the definition set forth in said MSEC document.*

*1.04 "Covered individual" means the participant, the participant's spouse or a dependent of the participant as defined in the MSEC.*

*1.05 "Employer" means the State of Missouri including any agency, or department of the State of Missouri other than the University of Missouri and Southeast Missouri State University.*

*1.06 "PHI" means protected health information.*

*1.07 "Protected health information" means information that is created or received by MSEFMBP and relates to the past, present, or future physical or mental health or condition of a covered individual; the provision of health care to a covered individual; or the past, present, or future payment for the provision of health care to a covered individual; and that identifies the covered individual or for which there is a reasonable basis to believe the information can be used to identify the covered individual. Protected health information includes information of persons living or deceased.*

ARTICLE TWO  
STATEMENT OF PURPOSE

*2.01 The purpose of this MSEFMBP is to make possible the inclusion of medical expenses in the group of benefits which may be selected by participants of the related MSEC and to satisfy the requirement of a written plan with respect to a medical expenses plan as set forth in the Internal Revenue Code.*

ARTICLE THREE  
ELIGIBILITY

*3.01 Any person who is eligible to participate in the related MSEC is eligible to select Flexible Medical Benefits as an optional benefit under the MSEC subject, however, to all terms, provisions and conditions set forth herein. The establishment of this MSEFMBP in the form of a separate document is not intended, nor shall it be so interpreted or construed, as expanding or enlarging the rights or privileges of any participant for payment or reimbursement above the amount set forth in the related MSEC.*

*3.02 Participants who elect to participate in this MSEFMBP shall elect to participate for the full Plan Year. Participants may arrange to have contributions made to the Plan as specified in the MSEC, section 6.01, so long as the participant remains an employee of the employer. Participation and coverage shall cease upon separation of service as of the last day of the month in which the last contribution was received.*

*3.03 No participant in this MSEFMBP may modify or revoke an election with respect to the Plan Year, except under the conditions specified in MSEC, section 3.09. In no case may a decrease in the amount of election result in a return of contributions to the participant.*

ARTICLE FOUR  
LIMITATIONS AND RESTRICTIONS ON PAYMENTS FROM THE PLAN

*4.01 Medical care expenses as defined herein will be eligible for payment from the MSEFMBP to the extent of the permissible amount selected by the participant pursuant to the MSEC, sections 3.04 and 4.01(b). Claims paid by any other accident*



*or health plan, whether or not maintained by the employer, are not reimbursable under this MSEFMBP.*

*4.02 Claims for reimbursement of medical care expenses must be submitted to the Plan Administrator and must be accompanied by invoices or such other reasonable evidence of the expenditure as may be satisfactory to the Plan Administrator. Such evidence must include a written statement from an independent third party stating the date the medical expense was incurred and the amount of such expense along with a signed statement from the participant that the expense has not been reimbursed and will not be reimbursed from any other source. In no event shall it be the responsibility of the Plan Administrator or the Office of Administration to make inquiry concerning the accuracy of any such statement or certification. No reimbursements for any Plan Year will be made prior to February 1 of that Plan Year.*

*4.03 No payment of medical care expenses shall be made from the MSEFMBP to any participant which is in excess of the amount designated by the participant as the permissible amount defined in the MSECP, section 3.04.*

*4.04 No payment shall be made for any medical care expense incurred after a participant has ceased being a participant in this MSEFMBP.*

*4.05 Payments to participants shall be suspended whenever the designated contribution amount is not received by the time the next required payment is due. Payments will resume when the required contribution amounts are paid in full.*

#### ARTICLE FIVE MISCELLANEOUS

*5.01 Reasonable notification of the availability and terms of this MSEFMBP and the related MSECP shall be provided by the employer to all employees.*

*5.02 Within forty-five (45) days following the end of each Plan Year, the Plan Administrator shall furnish to each participant under this MSEFMBP a written statement showing the amounts paid for medical expenses claimed by the participant relating to the previous calendar year.*

#### ARTICLE SIX CONTINUATION COVERAGE

*6.01 In accordance with Section 42 United States Code 300bb, and notwithstanding any other provision in the MSEFMBP, a participant or his/her spouse or dependent may be eligible to elect to continue the coverage under the MSEFMBP though the participant's election to receive benefits expired or was terminated, under the following circumstances:*

- (a) Death of the participant;*
- (b) Termination (other than for gross misconduct) or reduction of hours of the participant;*
- (c) Divorce or legal separation of the participant; and*
- (d) A dependent child ceasing to be a dependent child under the terms of this plan.*

*The right to continuation coverage shall only be available if on the date of the qualifying event the participant's remaining benefits for the current plan year are greater than the participant's remaining premium payments.*

*6.02 When the MSEFMBP is notified that one of the events described in section 6.01 has happened, it will in turn notify the eligible person(s) of the right to choose continuation coverage. The election period for continuation coverage begins when coverage would otherwise terminate under the MSEFMBP and ends sixty (60) days after the latter of the date when coverage would otherwise terminate, or the date notice of the right to continue coverage is provided by the Plan Administrator. It is the responsibility of the employee-participant or a responsible family member to inform the Plan Administrator of the occurrence of the event according continuation coverage and the election to apply for continuation coverage based upon the events described in section 6.01(c) and 6.01(d) above. It is the responsibility of the employer to inform the Plan Administrator of the occurrence of the event according continuation coverage and the election to apply for continuation coverage based upon the events described in section 6.01(a) and 6.01(b) above.*

*6.03 A premium may be charged to the participant, spouse or dependent, as the case may be, for any period of continuation coverage equal to not more than one hundred two percent (102%) of the cost of providing coverage for the period to similarly situated participants, spouses or dependents. Any additional premium amount in excess of one hundred percent (100%) of the cost of providing coverage for the period to similarly situated participants, spouses or dependents, shall not be credited to the participant's account and shall be treated as an additional administrative charge. Continuation coverage will not extend beyond the end of the current plan year. However, coverage may terminate earlier if:*

- (a) The employer ceases to provide any medical reimbursement plans to any employee;*
- (b) The premiums described above are not paid within thirty (30) days of their due date; or*
- (c) A party electing continuation coverage becomes covered under another group health plan or entitled to Medicare benefits.*

*6.04 Payments for expenses incurred during any period of continuation shall not be made until the contributions for that period are received by the MSECP.*

*6.05 Continuation coverage shall be provided in accordance with the requirements of Section 42 U.S.C. 300bb, all of which requirements are incorporated herein by reference.*

ARTICLE SEVEN  
FAMILY AND MEDICAL LEAVE

7.01 An employee is entitled to continue coverage under the MSEFMBP during FMLA leave or during a period of duty in the Uniformed Services lasting more than thirty-one (31) days. An employee making premium payments who chooses to continue coverage while on FMLA leave is responsible for the share of premiums that the employee was paying while working.

7.02 An employee who continues coverage while on paid or unpaid FMLA leave may choose from one or both of the following payment options. These options are referred to in this section as *pre-pay* and *pay-as-you-go*.

(a) *Pre-pay*.

(1) Under the *pre-pay* option, an employee may pay, prior to commencement of the FMLA leave period, the amounts due for the FMLA leave period.

(2) Contributions under the *pre-pay* option may be made on a pre-tax salary reduction basis from any taxable compensation.

(3) Contributions under the *pre-pay* option may also be made on an after-tax basis.

(b) *Pay-as-you-go*.

(1) Under the *pay-as-you-go* option, employees may pay their premium payments on the same schedule as payments would be made if the employee were not on leave or under any other payment schedule permitted by the Labor Regulations at 29 CFR 825.210(c) (i.e., on the same schedule as payments are made under the Consolidated Omnibus Reconciliation Act of 1985, Public Law 99-272; under the employer's existing rules for payment by employees on leave without pay; or under any other system voluntarily agreed to between the employer and the employee that is not inconsistent with this section or with 29 CFR 825.210(c)).

(2) Contributions under the *pay-as-you-go* option may be made on a pre-tax basis to the extent that the contributions are made from taxable compensation that is due the employee during the leave period, and provided that all cafeteria plan requirements are satisfied.

(3) Coverage under the MSEFMBP will be terminated for any employee who fails to make required premium payments while on FMLA leave.

ARTICLE EIGHT  
AMENDMENT AND TERMINATION

8.01 The employer reserves to itself the right to amend this MSEFMBP in any manner which it deems to be necessary or desirable and shall amend the MSEFMBP in any respect necessary to conform to the provisions of the Internal Revenue Code, or relevant regulations promulgated thereunder, and further reserves the right to terminate the MSEFMBP by appropriate action.

ARTICLE NINE  
PRIVACY POLICY

9.01 The MSEFMBP will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

9.02 *Meaning of Payment.*

Payment has the meaning specified in the Code of Federal Regulations §164.501, specifically:

(1) The activities undertaken by:

i. A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or

ii. A health care provider or health plan to obtain or provide reimbursement for the provision of health care; and

(2) The activities in paragraph (1) of this definition relate to the individual to whom health care is provided and include, but are not limited to:

i. Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

ii. Risk adjusting amounts due based on enrollee health status and demographic characteristics;

iii. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;

iv. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

v. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and

vi. Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement:

A. Name and address;

B. Date of birth;

C. Social security number;

D. Payment history;

E. Account number; and

F. Name and address of the health care provider and/or health plan.

### 9.03 Meaning of Health Care Operations.

*Health care operations has the meaning as specified in the Code of Federal Regulations §164.501, specifically, health care operations means any of the following activities of the covered entity to the extent that the activities are related to covered functions:*

*(1) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;*

*(2) Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;*

*(3) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of §164.514(g) are met, if applicable;*

*(4) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;*

*(5) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and*

*(6) Business management and general administrative activities of the entity, including, but not limited to:*

*i. Management activities relating to implementation of and compliance with the requirements of this subchapter;*

*ii. Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer;*

*iii. Resolution of internal grievances;*

*iv. The sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and*

*v. Consistent with the applicable requirements of §164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.*

### 9.04 As required by law and authorization.

*The MSEFMBP will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary. With an authorization, the MSEFMBP will disclose PHI to the Employer's other medical, disability and workers' compensation plans for purposes related to administration of those plans.*

### 9.05 Disclosures to the Employer.

*The MSEFMBP will disclose PHI to the Employer as sponsor of the MSEFMBP provided that the Employer agrees to:*

*(1) Not use or further disclose PHI other than as permitted or required by this MSEFMBP document or as required by law;*

*(2) Ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the MSEFMBP agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;*

*(3) Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual;*

*(4) Not use or disclose PHI in conjunction with any other benefit or employee benefit plan of the Employer unless authorized by the individual;*

*(5) Report to the MSEFMBP any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;*

*(6) Make PHI available to an individual in accordance with HIPAA's access requirements;*

*(7) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;*

*(8) Make available the information required to provide an accounting of disclosures;*

*(9) Make internal practices, books and records relating to the use and disclosure of PHI received from the MSEFMBP available to the Secretary of Health and Human Services for the purposes of determining the MSEFMBP's compliance with HIPAA; and*

*(10) If feasible, return or destroy all PHI received from the MSEFMBP that the Employer still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).*

### 9.06 Employees with access to PHI.

*In accordance with HIPAA, only the following employees of the Employer will be given access to PHI solely for the purpose of performing Employer Plan administrations functions:*

*(1) Any employee responsible for establishing and maintaining employee deduction and reduction records for the Employer;*

*(2) Any employee with oversight responsibility for management of the MSEFMBP or any component of the MSEFMBP.*

*If the above employees do not comply with this MSEFMBP document, the Employer shall provide a mechanism for resolving issues of noncompliance including disciplinary sanctions.*

### 9.07 HIPAA Compliance.

*It is intended that this MSEFMBP meet all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA) and of all regulations issued thereunder. This MSEFMBP shall be construed, operated and administered accordingly,*

*and in the event of any conflict between any part, clause or provision of this MSEFMBP and HIPAA, the provisions of HIPAA shall be deemed controlling, and any conflicting part, clause or provision of this MSEFMBP shall be deemed superseded to the extent of the conflict. ]*

**APPENDIX A**  
**MISSOURI STATE EMPLOYEES' CAFETERIA PLAN DOCUMENT**

**Cafeteria Plan  
for the Employees of  
the State of Missouri**

**Plan Document**

**Effective January 1, 2011  
(with an original effective date of January 1, 1992)**

**Cafeteria Plan  
for the Employees of  
the State of Missouri**

**Plan Document**

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**Section 1  
Introduction**

**1.1 Establishment of the Plan**

The State of Missouri (the "Employer") hereby amends the State of Missouri Cafeteria Plan (the "Plan") effective January 1, 2011 (the "Effective Date"). The original Plan was effective January 1, 1992.

**1.2 Purpose of the Plan**

This Plan allows an Employee to participate in the following Benefit Options:

- Premium Payment Plan (PPP) to make pre-tax Salary Reduction Contributions to pay the Employee's share of the premium or contribution for the Health Plan.
- Health Flexible Spending Account (Health FSA) to make pre-tax Salary Reduction Contributions to an account for reimbursement of certain Health Care Expenses.
- Dependent Care Assistance Program (DCAP) to make pre-tax Salary Reduction Contributions to an account for reimbursement of certain Dependent Care Expenses.
- Health Savings Account Contribution Benefit (HSA Contribution Benefit) to make pre-tax Salary Reduction Contributions to a Health Savings Account.

**1.3 Legal Status**

This Plan is intended to qualify as a "cafeteria plan" under the Code §125, and regulations issued thereunder and shall be interpreted to accomplish that objective.

The Health FSA is intended to qualify as a self-insured health reimbursement plan under Code §105, and the Health Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees' gross income under Code §105(b).

The DCAP is intended to qualify as a dependent care assistance program under Code §129, and the Dependent Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees' gross income under Code §129(a).

The HSA Contribution Benefit is intended to meet all requirements of §223 of the Code.

Although reprinted within this document, the Health FSA, the DCAP and the HSA Contribution Benefit are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §§105 and 129. The Health FSA is also a separate plan for purposes of applicable provisions of COBRA and HIPAA.

**1.4 Capitalized Terms**

Many of the terms used in this document begin with a capital letter. These terms have special meaning under the Plan and are defined in the Glossary at the end of this document or in other

relevant Sections. When reading the provisions of the Plan, please refer to the Glossary at the end of this document. Becoming familiar with the terms defined there will provide a better understanding of the procedures and Benefits described.



**Section 2**  
**General Information**

<b>Name of the Cafeteria Plan</b>	<b>State of Missouri Cafeteria Plan</b>
<b>Name of Employer</b>	<b>State of Missouri</b>
<b>Address of Plan</b>	<b>Office of Administration, P.O. Box 809, Jefferson City, MO 65102-0809</b>
<b>Plan Administrator</b>	<b>State of Missouri/Office of Administration</b>
<b>Plan Sponsor and its IRS</b>	<b>State of Missouri/Office of Administration</b>
<b>Employer Identification Number</b>	<b>44-6000987</b>
<b>Named Fiduciary &amp; Agent for Service of Legal Process</b>	<b>State of Missouri</b>
<b>Type of Administration</b>	<b>The Plan is administered by the Plan Administrator with Benefits provided in accordance with the provisions of the State of Missouri Cafeteria Plan. It is not financed by an insurance company and Benefits are not guaranteed by a contract of insurance. State of Missouri may hire a third party to perform some of its administrative duties such as claim payments and enrollment.</b>
<b>Plan Number</b>	<b>501</b>
<b>Benefit Option Year</b>	<b>The twelve-month period ending December 31.</b>
<b>Plan Effective Date</b>	<b>January 1, 2011, with an original effective date of January 1, 1992</b>
<b>Claims Administrator</b>	<b>Application Software, Inc., dba ASI, dba ASIFlex</b>
<b>Plan Renewal Date</b>	<b>January 1</b>
<b>Internal Revenue Code and Other Federal Compliance</b>	<b>It is intended that this Plan meet all applicable requirements of the Internal Revenue Code of 1986 (the "Code") and other federal regulations. In the event of any conflict between this Plan and the Code or other federal regulations, the provisions of the Code and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.</b>
<b>Discretionary Authority</b>	<b>The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine the appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained.</b>

In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all Plan documents, and make all interpretive and factual determinations as to whether any individual is entitled to receive any Benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation shall be subject to review only if it is arbitrary, capricious, or otherwise an abuse of discretion.

Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any Benefits or making any claim for Benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes in its sole discretion and further constitutes agreement to the limited standard and scope of review described by this section -- Section 2.

Section 3  
**Benefit Options and Method of Funding**

**3.1 Benefits Offered**

Each Employee may elect to participate in one or more of the following Benefits:

- **Premium Payment Plan (PPP)** as described in Schedule A.
- **Health Flexible Spending Account (Health FSA)** as described in Schedule B.
- **Health Savings Account Contribution Benefit (HSA Contribution Benefit)** as described in Schedule C.
- **Dependent Care Assistance Program (DCAP)** as described in Schedule D.

Benefits under the Plan shall not be provided in the form of deferred Compensation.

**3.2 Employer and Participant Contributions**

- **Employer Contributions.** The Employer may, but is not required to, contribute to any of the Benefit Options. There are no Employer Contributions for the PPP under this Plan; however, if the Participant elects the PPP as described in Schedule A, the Employer may contribute toward the Health Plan as provided in the respective plan or policy of the Employer.
- **Participant Contributions.** The Employer shall withhold from a Participant's Compensation by Salary Reduction on a pre-tax basis, or with after-tax deductions, an amount equal to the Contributions required for the Benefits elected by the Participant under the Salary Reduction Agreement. The maximum amount of Salary Reductions shall not exceed the aggregate cost of the Benefits elected.

**3.3 Computing Salary Reduction Contributions**

- **Salary Reductions per Pay Period.** The Participant's Salary Reduction is an amount equal to:
  - The annual election for such Benefits payable on a semi-monthly or monthly basis in the Period of Coverage;
  - An amount otherwise agreed upon between the Employer and the Participant; or
  - An amount deemed appropriate by the Plan Administrator. (Example: in the event of a shortage of reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate.)
- **Salary Reductions Following a Change of Elections.** If the Participant changes his or her election under the PPP, Health FSA, or DCAP, as permitted under the Plan, the Salary Reductions will be, for the Benefits affected, calculated as follows:
  - An amount equal to:

- The new annual amount elected pursuant to the Method of Timing and Elections section below;
- Less the aggregate Contributions, if any, for the period prior to such election change;
- Payable over the remaining term of the Period of Coverage commencing with the election change;
- An amount otherwise agreed upon between the Employer and the Participant; or
- An amount deemed appropriate by the Plan Administrator. (Example: in the event of a shortage of reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate.)
- **Salary Reductions Considered Employer Contributions for Certain Purposes.** Salary Reductions to pay for the Participant's share of the Contributions for Benefit Options elected for purposes of this Plan and the Code are considered Employer Contributions.
- **Salary Reduction Balance Upon Termination of Coverage.** If, as of the date that coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the required Contributions necessary for Benefit Options elected up to the date of termination, the Employer will either return the excess to the Participant as additional taxable wages or recoup the amount due through Salary Reduction amounts from any remaining Compensation.
- **After-Tax Contributions for PPP.** After-tax Contributions for the Health Plan will be paid outside of this Plan.

#### 3.4 Funding This Plan

- **Benefits Paid from General Assets.** All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer nor the Plan Administrator to maintain any fund or to segregate any amount for the Participant's benefit. Neither the Participant, nor any other person, shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets, it may hire a third party administrator to perform some of its administrative duties such as claims payments and enrollment.
- **Participant Bookkeeping Account.** While all Benefits are to be paid from the general assets of the Employer, the Employer will keep a bookkeeping account in the name of each Participant. The bookkeeping account is used to track allocation and payment of Plan Benefits. The Plan Administrator will establish and maintain under each Participant's bookkeeping account a subaccount for each Benefit Option elected by each Participant.
- **Maximum Contributions.** The maximum Contributions that may be made under this Plan for the Participant are the total of the maximums that may be elected for the PPP as described in

**Schedule A, Health FSA as described in Schedule B, HSA Contribution Benefit as described in Schedule C and the DCAP as described in Schedule D.**

**Section 4**  
**Eligibility and Participation****4.1 Eligibility to Participate**

An individual is eligible to participate in this Plan if such individual meets the definition of Employee as set forth in the Glossary.

Eligibility requirements to participate in the individual Benefit Options may vary from the eligibility requirements to participate in this Plan.

**4.2 Required Salary Reduction Agreement**

To participate in the Health FSA or DCAP, an Employee must complete, sign and return to the Plan Administrator a Salary Reduction Agreement by the deadline designated by the Plan Administrator. If an Employee fails to return a Salary Reduction Agreement, the Employee is deemed to have elected cash and will not be allowed to change such election until the next Open Enrollment unless the Employee experiences an event permitting an election change mid-year.

The Employee may begin participation on the 1st of the month coincident with or next following the date on which the Employee has met the Plan's eligibility requirements or in accordance with the Enrollment requirements each year.

**4.3 Termination of Participation**

A Participant will terminate participation in this Plan upon the earlier of:

- The expiration of the Period of Coverage for which the Employee has elected to participate unless during the Open Enrollment Period for the next Plan Year the Employee elects to continue participating;
- The termination of this Plan; or
- The date on which the Employee ceases to be an Employee because of retirement, termination of employment, layoff, reduction in hours, or any other reason. Eligibility may continue beyond such date for purposes of COBRA coverage, where applicable as set forth in the respective Schedule attached hereto, as may be permitted by the Plan Administrator on a uniform and consistent basis, but not beyond the end of the current Plan Year.

**False or Fraudulent Claims.** The Plan Administrator has the authority to terminate participation in the Plan if it has been determined that a Participant has filed a false or fraudulent claim for Benefits. In addition, an Employee filing a false or fraudulent claim is subject to disciplinary action, up to and including termination of employment.

Termination of participation in this Plan will automatically revoke the Participant's participation in the elected Benefit Options, according to the terms thereof.

#### **4.4 Rehired Employees**

If a Participant terminates employment with the Employer for any reason, including, but not limited to, disability, retirement, layoff, leave of absence without pay, or voluntary resignation, and then is rehired within the same Plan Year and within 30 days or less of the date of termination of employment, the Employee will be reinstated with the same elections that the Participant had prior to termination. If the Employer rehires a former Participant within the same Plan Year but more than 30 days following termination of employment and the Participant is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire.

#### **4.5 Eligibility Rules Regarding the Health FSA**

An Employee enrolled in a Health Savings Account (HSA) is not eligible to enroll in the Health FSA.

#### **4.6 Eligibility Rules Regarding the HSA Contribution Benefit**

An Employee must be an HSA Employee to elect to participate in the HSA Contribution Benefit Plan.

Only Employees who satisfy the following conditions may be considered an HSA Employee:

- Covered under a qualifying High Deductible Health Plan (HDHP) maintained by the Employer;
- Opened an HSA with the custodian chosen by the Employer;
- Not covered under any other non-HDHP maintained by one Employer that is determined by the Employer to offer disqualifying health coverage;
- Not claimed as a tax dependent by anyone else;
- Not enrolled in Medicare coverage; and
- Eligible to participate in the Plan.

#### **4.7 FMLA Leaves Of Absence**

**Health Benefits.** Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under FMLA then to the extent required by FMLA, the Participant will be entitled to continue the Benefits that provide health coverage on the same terms and conditions as if the Participant were still an active Employee. For example, the Employer will continue to pay its share of the Contribution to the extent the Participant opts to continue coverage. In the event of unpaid FMLA leave, a Participant may elect to continue such Benefits.

If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contribution:

- With after-tax dollars, by sending monthly payments to the Employer's designee by the due date established by the Employer;

- With pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any; or
- By pre-paying all or a portion of the Contribution for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation.

To pre-pay the Contribution, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available. Pre-tax dollars may not be used to fund coverage during the next Plan Year.

Coverage will terminate if Contributions are not received by the due date established by the Employer. If a Participant's coverage ceases while on FMLA leave for any reason, including for non-payment of Contributions, the Participant will be entitled to re-enter upon return from such leave on the same basis as the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA.

A Participant whose coverage ceased under any of the aforementioned plans will be entitled to elect whether to be reinstated in such plans at the same coverage level as in effect before the FMLA leave with increased Contributions for the remaining Period of Coverage, or at a coverage level that is reduced pro-rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro-rata for the period of FMLA leave, the amount withheld from a Participant's Compensation on a payroll-by-payroll basis for the purpose of paying for his or her Contributions will be equal to the amount withheld prior to the period of FMLA leave.

**Non-Health Benefits.** If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as DCAP Benefits) is to be determined by the Employer's policy for providing such Benefits when the Participant is on leave not qualified as an FMLA leave of absence, as described below. If such policy permits a Participant to discontinue Contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

#### 4.8 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax Contributions while on leave or with catch-up Contributions after the leave ends, as may be determined by the Plan Administrator.

If a Participant goes on an unpaid leave that affects eligibility, the election change rules set forth by this Plan will apply. To the extent COBRA applies, the Participant may continue coverage under COBRA.

#### 4.9 Death

A Participant's beneficiaries or representative of the Participant's estate, may submit claims for expenses that the Participant incurred through the date of death. A Participant may designate a



specific beneficiary for this purpose. If no beneficiary is specified, the Plan Administrator or its designee may designate the Participant's Spouse, another Dependent, or representative of the estate. Claims incurred by the Participant's covered Spouse or any other of the Participant's covered Dependents prior to the end of the month in which the Participant dies may also be submitted for reimbursement.

#### **4.10 COBRA**

Under the COBRA rules, as discussed in the attached Schedules B and C, where applicable, the Participant's Spouse and Dependents may be able to continue to participate under the Health FSA through the end of the Period of Coverage in which the Participant dies. The Participant's Spouse and Dependents may be required to continue making Contributions to continue their participation.

#### **4.11 USERRA**

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under USERRA, then to the extent required by USERRA, the Employer will continue the Benefits that provide health coverage on the same terms and conditions as if the Participant were still an active Employee. In the event of unpaid USERRA leave, a Participant may elect to continue such Benefits during the leave.

If the Participant elects to continue coverage while on USERRA leave, then the Participant may pay his or her share of the Contribution with:

- After-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer; or
- Pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any, including unused sick days and vacation days.

Coverage will terminate if Contributions are not received by the due date established by the Employer. If a Participant's coverage ceases while on USERRA leave for any reason, including for non-payment of Contributions, the Participant will be entitled to re-enter such Benefit upon return from such leave on the date of such resumption of employment and will have the same opportunities to make elections under this Plan as persons returning from non-USERRA leaves. Regardless of anything to the contrary in this Plan, an Employee returning from USERRA leave has no greater right to Benefits for the remainder of the Plan Year than an Employee who has been continuously working during the Plan Year.

**Section 5**  
**Method of Timing and Elections****5.1 Initial Election**

An Employee must complete, sign and return a Salary Reduction Agreement within the election-period set forth therein to enroll in the Benefit Options, other than the PPP.

Unless otherwise specified by the Employer, an Employee who first becomes eligible to participate in the Plan mid-year will commence participation on the 1st day of the month coinciding with or after the date the Employee completes, signs and returns a Salary Reduction Agreement or completes a Salary Reduction Agreement using the electronic system produced by the Employer (if any), within the election period set forth therein.

Eligibility for Benefits shall be subject to the additional requirements, if any, specified in the applicable Benefit Option (see Glossary for definition). The provisions of this Plan are not intended to override any exclusions, eligibility requirements or waiting periods specified in the applicable Benefit Options.

**5.2 Open Enrollment**

During each Open Enrollment Period, the Plan Administrator shall make available a Salary Reduction Agreement to each Employee who is eligible to participate in the Plan. The Salary Reduction shall enable the Employee to elect to participate in the Benefit Options for the next Plan Year, and to authorize the necessary Salary Reductions to pay for the Benefits elected. The Employee must complete sign and return the Salary Reduction Agreement or complete an election using the electronic system provided by the Employer, if any, to the Plan Administrator on or before the last day of the Open Enrollment Period. There is an exception of automatic elections in the PPP.

If an Employee makes an election to participate during an Open Enrollment Period, then the Employee will become a Participant on the first day of the next Plan Year.

The Employer may, in lieu of a Salary Reduction Agreement, provide an electronic method for Employees to use to make elections. The Employer may require Employees to use the electronic system to make elections. Use of an electronic system will have the same effect as a signed Salary Reduction Agreement.

**5.3 Failure To Elect**

If an Employee fails to complete, sign and return a Salary Reduction Agreement or fails to complete an election using the electronic system (if any) provided by the Employer within the time described in the Elections paragraphs as discussed immediately above, then the Employee will be deemed to have elected to receive his or her entire Compensation in cash (excluding the PPP). The Employer provides for an automatic election for the PPP, therefore, the Employee will have also agreed to a Salary Reduction for such Employee's Contribution to the PPP.

Such Employee may not enroll in the Plan:

- Until the next Open Enrollment Period; or

- **Until an event occurs that would justify a mid-year election change as described in the Irrevocability of Election and Exceptions section below.**

**Section 6**  
**Irrevocability of Elections and Exceptions****6.1 Irrevocability of Elections**

A Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates, except as described in this Section.

The irrevocability rules do not apply to the HSA Contribution Benefit election.

The rules regarding irrevocability of elections and exceptions are quite complex. The Plan Administrator will interpret these rules in accordance with prevailing IRS guidance.

**6.2 Procedure for Making New Election If Exception to Irrevocability Applies**

- **Timing for Making New Election if Exception to Irrevocability Applies.** A Participant may make a new election within 30 days of the occurrence of an event described in section 6.4 below, if the election under the new Salary Reduction Agreement is made on account of and corresponds to the event. A Change in Status, as defined below, that automatically results in ineligibility in the Health Plan shall automatically result in a corresponding election change, whether or not requested.
- **Effective Date of New Election.** Elections made pursuant to this Section shall be effective on the 1st of the month following or coinciding with the Plan Administrator's receipt and approval of the election request for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in "Certain Judgments, Decrees and Orders" or for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only.
- **Changes.** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Salary Reduction Agreement or other document.
- **Effect on Maximum Benefits.** Any change in an election affecting annual Contributions to the Health FSA or DCAP also will change the maximum reimbursement Benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement Benefits for the balance of the Period of Coverage shall be calculated by adding:
  - Any Contributions made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election; to
  - The total Contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Benefit Option; reduced by
  - All reimbursements made during the entire Period of Coverage.

### **6.3 Change in Status Defined**

A Participant may make a new election that corresponds to a gain or loss of eligibility and coverage under this Plan or under any other plan maintained by the Employer or a plan of the Spouse's or Dependent's employer that was caused by the occurrence of a Change in Status. A Change in Status is any of the events described below, as well as any other events included under subsequent changes to Code §125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

- **Legal Marital Status.** A change in a Participant's legal marital status including marriage, death of a Spouse, divorce, legal separation or annulment;
- **Number of Dependents.** Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption. In the case of the DCAP, a change in the number of Qualifying Individuals as defined in Code §21(b)(1);
- **Employment Status.** Any of the following events that change the employment status of the Participant, Spouse or Dependents:
  - A termination or commencement of employment;
  - A commencement of or return from an unpaid leave of absence;
  - A change in worksite; or
  - If the eligibility conditions of this Plan or another employee benefit plan of the Participant, Spouse or Dependent depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes, or ceases to be, eligible under this Plan or another employee benefit plan;
- **Dependent Eligibility Requirements.** An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular Benefit; and
- **Change in Residence.** A change in the place of residence of the Participant, Spouse or Dependent(s).

### **6.4 Events Permitting Exception to Irrevocability Rule**

A Participant may change an election as described below upon the occurrence of the stated events for the applicable Benefit Option.

The following rules shall apply to all Benefit Options except where expressly limited below.

- **Open Enrollment Period.** A Participant may change an election during the Open Enrollment Period.

- **Termination of Employment.** A Participant's election will terminate upon termination of employment as described in the Eligibility and Participation section above.
- **Leave of Absence.** A Participant may change an election upon a leave of absence as described in the Eligibility and Participation section above.
- **Change in Status.** *(Applies to the PPP, Health FSA, and DCAP as limited below.)* A Participant may change the actual or deemed election under the Plan upon the occurrence of a Change in Status, but only if such election change corresponds with a gain or loss of eligibility and coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer, referred to as the general consistency requirement.

A Change in Status that affects eligibility for coverage also includes a Change in Status that results in an increase or decrease in the number of an Employee's family members who may benefit from the coverage.

The Plan Administrator, on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change satisfies the general consistency requirement. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter elections based on the specified Change in Status:

- **Loss of Spouse or Dependent Eligibility.** For a Change in Status involving a Participant's divorce, annulment or legal separation, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel health plan coverage and deduction plans offered under the Voluntary Payroll Vendors for:
  - The Spouse involved in the divorce, annulment, or legal separation;
  - The deceased Spouse or Dependent; or
  - The Dependent that ceased to satisfy the eligibility requirements.

Canceling coverage for any other individual under these circumstances fails to correspond with that Change in Status.

Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA or similar health plan continuation coverage under the Employer's plan, then the Participant may increase his or her election to pay for such coverage. This rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation.

- **Gain of Coverage Eligibility Under Another Employer's Plan.** When a Participant, Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of that Participant's Spouse or Dependent, a Participant may elect to terminate or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has

obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

- **Special Consistency Rule for DCAP Benefits.** With respect to the DCAP, the Participant may change or terminate the Participant's election upon a Change in Status if:
  - Such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an Employer's plan; or
  - The election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code §129.
- **HIPAA Special Enrollment Rights (*Applies to the PPP only*).** If the Participant, the Participant's Spouse or Dependent is entitled to special enrollment rights under a group health plan as required by HIPAA, then the Participant may revoke a prior election for group health plan coverage and make a new election provided that the election change corresponds with such HIPAA special enrollment right. As more specifically defined by HIPAA, a special enrollment right will arise in the following circumstances:
  - The Participant, Spouse or Dependent declined to enroll in group health plan coverage because the Participant, the Participant's Spouse or Dependent had coverage, and eligibility for such coverage is subsequently lost because the coverage was provided under COBRA and the COBRA coverage was exhausted; or the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated;
  - The Participant acquired a new Dependent as a result of marriage, birth, adoption or placement for adoption; or
  - The Employee or Dependents who are eligible but did not enroll for coverage when initially eligible and:
    - The Employee or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or
    - The Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, and the employee requests coverage under the Plan within 60 days after eligibility is determined.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change due to birth, adoption, or placement for adoption of a new Dependent child may, subject to the group health plan, be effective retroactively for up to 30 days.

- **Certain Judgments, Decrees and Orders. (*Applies to the PPP, Health FSA, but does not apply to the DCAP*).** If a judgment, decree, or order resulting from a divorce, legal separation,

annulment or change in legal custody, including a Qualified Medical Child Support Order (QMCSO) requires accident or health coverage, including an election for Health FSA Benefits for a Participant's Dependent child, a Participant may:

- Change an election to provide coverage for the Dependent child provided that the order requires the Participant to provide coverage; or
  - Change an election to revoke coverage for the Dependent child if the order requires that another individual provide coverage under that individual's plan and such coverage is actually provided.
- **Medicare and Medicaid.** *(Applies to the PPP, Health FSA, but does not apply to the DCAP).* If a Participant, Spouse or Dependent is enrolled in a Benefit under this Plan and becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the Health Plan covering the person, and the Health FSA coverage may be cancelled but not reduced. However, such cancellation will not be effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Further, if a Participant, Spouse, or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the Health FSA coverage.
  - **Change in Cost.** *(Applies to the PPP and DCAP as limited below, but does not apply to the Health FSA).* For purposes of this Section, "similar coverage" means coverage for the same category of Benefits for the same individuals.
    - **Insignificant Cost Changes.** The Participant is required to increase his or her elective Contributions to reflect insignificant increases in the required Contribution for the Benefit Options, and to decrease the elective Contributions to reflect insignificant decreases in the required Contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically make this increase or decrease in affected Participants' elective Contributions on a prospective basis.
    - **Significant Cost Increases.** If the Plan Administrator determines that the cost charged to an Employee for a Benefit significantly increases during a Period of Coverage, the Participant may:
      - Make a corresponding prospective increase to elective Contributions by increasing Salary Reductions;
      - Revoke the election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Option that provides similar coverage; or
      - Terminate coverage going forward if there is no other Benefit Option available that provides similar coverage.



The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant.

- **Significant Cost Decreases.** If the Plan Administrator determines that the cost of any Benefit (such as the premium for the Health Plan) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes:
  - Participants enrolled in that Benefit Option may make a corresponding prospective decrease in their elective contributions by decreasing Salary Reductions;
  - Participants who are enrolled in another benefit package option may change their election on a prospective basis to elect the Benefit Option that has decreased in cost; or
  - Employees who are otherwise eligible may elect the Benefit Option that has decreased in cost on a prospective basis, subject to the terms and limitations of the Benefit Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant.
- **Limitation on Change in Cost Provisions for DCAP Benefits.** The above "Change in Cost" provisions apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a relative of the Employee.
- **Change in Coverage.** (*Applies to the PPP and DCAP, but not to the Health FSA*). The definition of "similar coverage" applied in the Change of Cost provision above also applies here.
  - **Significant Curtailment.** Coverage under a Plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the Plan to constitute reduced coverage generally. If coverage is "significantly curtailed," Participants may elect coverage under a Benefit Option that provides similar coverage. In addition, if the coverage curtailment results in a "Loss of Coverage" as defined below, Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a curtailment is "significant," and whether a Loss of Coverage has occurred in accordance with prevailing IRS guidance.
    - **Significant Curtailment Without Loss of Coverage.** If the Plan Administrator determines that a Participant's coverage under a Benefit Option (or the Participant's, Spouse's or Dependent's coverage under the respective employer's plan) is significantly curtailed without a Loss of Coverage during a Period of Coverage, the Participant may revoke an election for the affected coverage and prospectively elect coverage under another Benefit Option if offered, that provides similar coverage.
    - **Significant Curtailment With a Loss of Coverage.** If the Plan Administrator determines that a Participant's coverage under this Plan (or the Participant's, Spouse's or Dependent's coverage under the respective employer's plan) is significantly curtailed, and such curtailment results in a Loss of Coverage during a Period of Coverage, the Participant may revoke an election for the affected coverage, and may either prospectively elect coverage under another Benefit Option that provides similar

coverage or drop coverage if no other Benefit Option providing similar coverage is offered by the Employer.

- **Definition of Loss of Coverage.** For purposes of this Section, a “Loss of Coverage” means a complete loss of coverage. In addition, the Plan Administrator in its sole discretion and on a uniform and consistent basis, may treat the following as a Loss of Coverage:
  - A substantial decrease in the health care providers available under the Benefit Package Plan;
  - A reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or
  - Any other similar fundamental loss of coverage.
- **Addition or Significant Improvement of a Benefit Option.** If during a Period of Coverage, the Plan adds a new Benefit Option or significantly improves an existing Benefit Option, the Plan Administrator may permit the following election changes:
  - Participants who are enrolled in a Benefit Option other than the newly-added or significantly improved Benefit Option that provides similar coverage may change their election on a prospective basis to cancel the current Benefit Option and instead elect the newly added or significantly improved Benefit Option; and
  - Employees who are otherwise eligible may elect the newly added or significantly improved Benefit Option on a prospective basis, subject to the terms and limitations of the Benefit Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Option.
- **Loss of Coverage Under Another Group Health Coverage.** A Participant may prospectively change an election to add group health coverage for the Participant, Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including, but not limited to, the following:
  - A children’s health insurance program (CHIP) under Title XXI of the Social Security Act;
  - A health care program of an Indian Tribal government (as defined in Code §7701(a)(40)), the Indian Health Service, or a tribal organization;
  - A state health benefits risk pool; or
  - A foreign government group health plan, subject to the terms and limitations of the applicable Benefit Option.

- **Change in Coverage Under Another Employer Plan.** A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan, including a plan of the Employer or a plan of the Spouse's or Dependent's employer, so long as:
  - The other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or
  - The Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan.

The Plan Administrator, on a uniform and consistent basis, will decide whether a requested change is because of, and corresponds with, a change made under the other employer plan.

- **Change in Dependent Care Service Provider.** A Participant may make a prospective election change that corresponds with a change in the dependent care service provider. For example:
  - If the Participant terminates one dependent care service provider and hires a new dependent care service provider, the Participant may change coverage to reflect the cost of the new service provider; and
  - If the Participant terminates a dependent care service provider because a relative or other person becomes available to take care of the child at no charge, the Participant may cancel coverage.

A Participant entitled to change an election as described in this Section must do so in accordance with the procedures described this Section.

#### **6.5 Election Modifications for HSA Contribution Benefits May be Changed Prospectively At Any Time**

As set forth in Schedule C, an election to make a Contribution to an HSA Contribution Benefit can be increased, decreased or revoked at any time on a prospective basis. Such election changes shall be effective no later than the 1<sup>st</sup> day of the next calendar month following the date that the election change was filed. No other Benefit Option election changes can occur as a result of a change in an HSA Contribution Benefit election except as otherwise permitted in this Section.

A Participant entitled to change an election as described in this Section must do so in accordance with the procedures described above.

#### **6.6 Election Modifications Required by Plan Administrator**

The Plan Administrator may require, at any time, any Participant or class of Participants to amend their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to:

- Satisfy any of the Code's nondiscrimination requirements applicable to this Plan or another cafeteria plan;
- Prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of Benefits hereunder than would otherwise be recognized;
- Maintain the qualified status of Benefits received under this Plan; or
- Satisfy any of the Code's nondiscrimination requirements or other limitations applicable to the Employer's qualified Plans.

In the event that Contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount, and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.



**THIS ISSUE CONTAINS  
TWO PARTS**

**END OF PART I**

## Rules About Rule Numbers

A rule number can only be used once. Once a rule number has been used for a rule, the same rule number cannot be used for another rule with a different subject.

Leave room in your chapters for expansion of rules. Normally rule numbers should be assigned in increments of ten (10)–15 CSR 30-997.010, 15 CSR 30-997.020, etc. This way, you should have room to add rules between numbers in the future should the need to do so arise.

For more about rule numbering please see page 5.02A of *Rulemaking 1-2-3 Drafting and Style Manual* which can be found online at <http://www.sos.mo.gov/adrules/manual/manual.asp>.

Volume 36, Number 3  
Pages 485–698  
February 1, 2011  
Part II

SALUS POPULI SUPREMA LEX ESTO

*“The welfare of the people shall be the supreme law.”*



ROBIN CARNAHAN  
SECRETARY OF STATE

MISSOURI  
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October 1, 2010	November 1, 2010	November 30, 2010	December 30, 2010
October 15, 2010	November 15, 2010	November 30, 2010	December 30, 2010
November 1, 2010	December 1, 2010	December 31, 2010	January 30, 2011
November 15, 2010	December 15, 2010	December 31, 2010	January 30, 2011
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June 1, 2011	July 1, 2011	July 31, 2011	August 30, 2011
June 15, 2011	July 15, 2011	July 31, 2011	August 30, 2011

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at <http://www.sos.mo.gov/adrules/pubsched.asp>

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## HOW TO CITE RULES AND RSMo

**RULES**—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 28, *Missouri Register*, page 27. The approved short form of citation is 28 MoReg 27.

The rules are codified in the *Code of State Regulations* in this system—

Title	Code of State Regulations	Division	Chapter	Rule
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

**RSMo**—The most recent version of the statute containing the section number and the date.

**Section 7  
Claims and Appeals**

**7.1 Claims Under the Plan**

If a claim for reimbursement under the Health FSA or DCAP is wholly or partially denied, or if the Participant is denied a Benefit under the Plan regarding the Participant's coverage under the Plan, then the claims procedure described below will apply.

**7.2 Notice from ASI**

If a claim is denied in whole or in part, ASI will notify the Participant in writing within 30 days of the date that ASI received the claim. This time may be extended for an additional 15 days for matters beyond the control of ASI, including cases where a claim is incomplete. ASI will provide written notice of any extension, including the reason(s) for the extension and the date a decision by ASI is expected to be made. When a claim is incomplete, the extension notice will also specifically describe the required information, and will allow the Participant at least 45 days from receipt of the notice to provide the specified information, and will have the effect of suspending the time for a decision on the claim until the specified information is provided. Notification of a denied claim will include:

- The specific reasons for the denial;
- The specific Plan provisions on which the denial is based;
- A description of any additional material or information necessary to validate the claim and an explanation of why such material or information is necessary; and
- Appropriate information on the steps to take to appeal ASI's adverse benefits determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information, and the right to file suit, where applicable, with respect to any adverse benefits determination after the final appeal of the claim.

**7.3 First Level Appeal to ASI**

If a claim is denied in whole or in part, the Participant, or the Participant's authorized representative, may request a review of the adverse benefits determination upon written application to ASI. The Participant, or the Participant's authorized representative, may request access to all relevant documents in order to evaluate whether to request review of an adverse benefits determination and, if review is requested, to prepare for such review.

An appeal of an adverse benefits determination must be made in writing within 90 days upon receipt of the notice that the claim was denied. If an appeal is not made within the above referenced timeframe all rights to appeal the adverse benefits determination and to file suit in court will be forfeited unless otherwise protected by law. A written appeal should include: additional documents, written comments, and any other information in support of the appeal. The review of the adverse benefits determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

#### 7.4 ASI Action on Appeal

ASI, within a reasonable time, but no later than 60 days after receipt of the request for review, will decide the appeal. ASI may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reasons for the decision on review;
- The specific Plan provisions on which the decision is based;
- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If an internal rule, guideline, protocol, or other similar criterion is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and
- Appropriate information on the steps to take to appeal ASI's adverse benefits determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information, and the right to file suit, where applicable, with respect to any adverse benefits determination after the final appeal of the claim.

#### 7.5 Second and Final Level Appeal to the Plan Administrator

If the decision on review affirms ASI's initial denial, the Participant may request a review of the adverse appeal determination upon written application to the Plan Administrator.

The Participant, or the Participant's authorized representative, may request access to all relevant documents in order to evaluate whether to request review of an adverse benefits determination and, if review is requested, to prepare for such review.

An appeal of an adverse appeal determination must be made in writing within 30 days after receipt of the notice that the first level appeal was denied. If an appeal is not made within the above referenced timeframe all rights to appeal the adverse benefits determination and to file suit in court will be forfeited unless otherwise protected by law. A written appeal should include: additional documents, written comments, and any other information in support of the appeal. The review of the adverse benefits determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the prior determination.

#### 7.6 Plan Administrator Action on Appeal

The Plan Administrator, within a reasonable time, but no later than 60 days after receipt of the request for review, will decide the appeal. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the prior claim denial.

The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reason(s) for the decision on review;
- The specific Plan provision(s) on which the decision is based;
- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If an internal rule, guideline, protocol, or other similar criterion is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request.

#### **7.7 Appeal Procedure for Eligibility or Salary Reduction Issues**

If the Participant is denied a Benefit under the Plan due to questions regarding the Participant's eligibility or entitlement for coverage under the Plan or regarding the amount the Participant owes, the Participant may request a review upon written application to the Plan Administrator.

The Participant, or the Participant's authorized representative, may request access to all relevant documents in order to evaluate whether to request review of an adverse benefits determination and if review is requested, to prepare for such review.

An appeal of an adverse benefits determination must be made in writing within 180 days upon receipt of the notice that the claim was denied. If an appeal is not made within the above referenced timeframe all rights to appeal the adverse benefits determination and to file suit in court will be forfeited unless otherwise protected by law. A written appeal should include: additional documents, written comments, and any other information in support of the appeal. The review of the adverse benefits determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The Plan Administrator, within a reasonable time, but no later than 30 days after receipt of the request for review, will decide the appeal. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reasons for the decision on review;
- The specific Plan provisions on which the decision is based;
- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

- **Appropriate information on the steps to take to appeal the Plan Administrator's adverse benefits determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information, and the right to file suit, where applicable, with respect to any adverse benefits determination after the final appeal of the claim.**

**If the decision on review affirms the Plan Administrator's denial, the Participant may request a review of the adverse appeal determination upon written application to the Plan Administrator. The Second and Final Level of Appeals Procedures described above will apply.**

**Section 8  
Plan Administration**

**8.1 Plan Administrator**

The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out in accordance with the terms of the Plan document and for the exclusive benefit of persons entitled to participate in this Plan and without discrimination among them.

**8.2 Powers of the Plan Administrator**

The Plan Administrator shall have such powers and duties as may be necessary or appropriate to discharge its functions hereunder. The Plan Administrator shall have final discretionary authority to make such decisions and all such determinations shall be final, conclusive and binding. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters hereunder. The Plan Administrator shall have the following discretionary authority:

- To construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of Benefits under this Plan (provided that the Plan Administrator shall exercise such exclusive power with respect to an appeal of a claim);
- To prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;
- To prepare and distribute information explaining this Plan and the Benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;
- To request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;
- To furnish each Employee and Participant with such reports in relation to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide Benefits under this Plan;
- To receive, review and keep on file such reports and information concerning the Benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;
- To appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and Benefit consultants;
- To sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

- To secure independent medical or other advice and require such evidence as deemed necessary to decide any claim or appeal; and
- To maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

### **8.3 Reliance on Participant, Tables, etc.**

The Plan Administrator may rely upon the Participant's direction, information or election as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by the Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

### **8.4 Outside Assistance**

The Plan Administrator may employ such counsel, accountants, claims administrators, consultants, actuaries and other person or persons as the Plan Administrator shall deem advisable. The Plan shall pay the compensation of such counsel, accountants, and other person or persons and any other reasonable expenses incurred by the Plan Administrator in the administration of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligations of the Employer and the Plan Administrator.

### **8.5 Insurance Contracts**

The Employer and/or some of the related employers adopting this Plan may have the right to enter into a contract with one or more insurance companies or self-fund for the purposes of providing any Benefits under the Plan; and to replace any of such insurance companies, contracts, or benefits. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer Contributions toward such insurance.

### **8.6 Fiduciary Liability**

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act.

### **8.7 Inability to Locate Payee**

If the Plan Administrator is unable to make payment to the Participant or another person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of the Participant or such other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to the Participant or such other person shall be forfeited one year after the date any such payment first became due.



**8.8 Effect of Mistake**

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the Participant's account, or the amount of Benefits paid or to be paid to the Participant or another person, the Plan Administrator shall, to the extent administratively possible and otherwise permissible under Code §125 or the regulations issued thereunder, correct by making the appropriate adjustments of such amounts as necessary to credit the Participant's account or such other person's account or withhold any amount due to the Plan or the Employer from Compensation paid by the Employer.

<p style="text-align: center;">Section 9 Amendment or Termination of the Plan</p>
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**9.1 Permanency**

While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in the paragraphs below.

**9.2 Right to Amend**

The Employer reserves the right to merge or consolidate the Plan and to make any amendment or restatement to the Plan from time-to-time, including those which are retroactive in effect. Such amendments may be applicable to any Participant.

Any amendment or restatement shall be deemed to be duly executed when ~~properly promulgated~~ in accordance with ~~under the requirements of~~ Chapter 536.

**9.3 Right to Terminate**

The Plan Administrator reserves the right to discontinue or terminate the Plan in whole or in part at any time without prejudice. A related employer has the right to discontinue participating in the Plan at the end of each calendar year.

**Section 10  
General Provisions**

**10.1 No Contract of Employment**

Nothing contained in the Plan shall be construed as a contract of employment with the Employer or as a right of any Employee to be continued in the employment of the Employer, or as a limitation of the right of the Employer to discharge any Employee, with or without cause.

**10.2 Compliance with Federal Mandates**

To the extent applicable for each Benefit Option, the Plan will provide Benefits in accordance with the requirements of all federal mandates, including USERRA, COBRA, and HIPAA. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

**10.3 Verification**

The Plan Administrator shall be entitled to require reasonable information to verify any claim or the status of any person as an Employee or Dependent. If the Participant does not supply the requested information within the applicable time limits or provide a release for such information, the Participant will not be entitled to Benefits under the Plan.

**10.4 Limitation of Rights**

Nothing appearing in or done pursuant to the Plan shall be held or construed:

- To give any person any legal or equitable right against the Employer, any of its employees, or persons connected therewith, except as provided by law; or
- To give any person any legal or equitable right to any assets of the Plan or any related trust, except as expressly provide herein or as provided by law.

**10.5 Non-Assignability of Rights**

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

**10.6 Governing Law**

This Plan is intended to be construed, and all rights and duties hereunder are governed, in accordance with the laws of the State of Missouri, except to the extent such laws are preempted by any federal law.

**10.7 Severability**

If any provision of the Plan is held invalid or unenforceable, its validity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

**10.8 Captions**

The captions contained herein are inserted only as a matter of convenience and for reference and in no way define, limit, enlarge or describe the scope or intent of the Plan nor in any way shall affect the Plan or the construction of any provision thereof.

**10.9 Federal Tax Disclaimer**

To ensure compliance with requirements imposed by the IRS to the extent this Plan Document or any Schedule contains advice relating to a federal tax issue, it is not intended or written to be used, and it may not be used, for the purpose of avoiding any penalties that may be imposed on the Participant or any other person or entity under the Internal Revenue Code or promoting, marketing or recommending to another party any transaction or matter addressed herein.

**10.10 No Guarantee of Tax Consequences**

Neither the Plan Administrator nor the Employer make any commitment or guarantee that any amounts paid to the Participant or for the Participant's benefit under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the Participant's obligation to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

**10.11 Indemnification of Employer**

If the Participant receives one or more payments or reimbursements under this Plan on a pre-tax Salary Reduction basis, and such payments do not qualify for such treatment under the Code, the Participant shall indemnify and reimburse the Employer for any liability the Employer may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

**Section 11  
HIPAA Privacy and Security**

**11.1 Provision of Protected Health Information to Employer**

For purposes of this Section, Protected Health Information (PHI) shall have the meaning as defined in HIPAA. PHI means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. PHI includes information of persons living or deceased.

Members of the Employer's workforce have access to the individually identifiable health information of Plan Participants for administrative functions of the Health FSA, plus any other Benefit Option which might be subject to the privacy and security provisions of HIPAA (hereinafter referred to collectively as the Plan). When this health information is provided to the Employer, it is PHI. HIPAA and its implementing regulations restrict the Employer's ability to use and disclose PHI. The Employer shall have access to PHI from the Plan only as permitted under this Section or as otherwise required or permitted by HIPAA.

**11.2 Permitted Disclosure of Enrollment/Disenrollment Information**

The Plan Administrator or ASI may disclose to the Employer information on whether the individual is participating in the Plan.

**11.3 Permitted Uses and Disclosure of Summary Health Information**

The Plan may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

Summary Health Information means information:

- That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and
- From which the required information has been deleted, except that the geographic information need only be aggregated to the level of a five-digit ZIP code.

**11.4 Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes**

Unless otherwise permitted by law, and subject to the conditions of disclosure and obtaining written certification described below, the Plan may disclose PHI to the Employer, provided that the Employer uses or discloses such PHI only for Plan Administration Purposes.

Plan Administration Purposes means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan Administration functions do not include functions performed by the Employer in connection with any

other benefit or benefit plan of the Employer, and they do not include any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

#### 11.5 Conditions of Disclosure for Plan Administration Purposes

Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it, the Employer shall:

- Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
- Not use or disclose the PHI for employment-related actions and decisions;
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance with HIPAA's privacy and security requirements;
- If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that the adequate separation between the Plan and the Employer (i.e., the "firewall"), required in 45 CFR §504(f)(2)(iii), is satisfied.

The Employer further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not

subject to these restrictions) on behalf of the Plan, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents, including subcontractors, to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Plan any security incident of which it becomes aware.

#### 11.6 Adequate Separation Between Plan and Employer

The Employer shall designate such employees of the Employer who need access to PHI in order to perform Plan administration functions that the Employer performs for the Plan such as quality assurance, auditing, monitoring, payroll, and appeals. No other persons shall have access to PHI. These specified employees, or classes of employees, shall only have access to and use of PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Plan.

In the event that any of these designated employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

The Employer will ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

#### 11.7 Certification of Plan Sponsor

The Plan shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth under the section entitled *Conditions of Disclosure for Plan Administration Purposes*.

#### 11.8 Organized Health Care Arrangement

The Plan Administrator intends the Plan to form part of an Organized Health Care Arrangement along with any other Benefit Option under a covered health plan under 45 CFR §160.103 provided by Employer.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the State of Missouri Cafeteria Plan, State of Missouri has caused this Plan to be executed in its name and on its behalf, on this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

State of Missouri

By: \_\_\_\_\_

Its: \_\_\_\_\_

Attest: \_\_\_\_\_

Its: \_\_\_\_\_



**Glossary**

**Capitalized terms used in the Plan have the following meanings:**

**Account** means the account(s) maintained under this Cafeteria Plan by the Plan Administrator to which allocations of employer contributions are made for each participant as required by this Cafeteria Plan and from which payments, as permitted by this Cafeteria Plan, shall be paid.

**Benefit or Benefits** means the Benefit Options offered under the Plan.

**Benefit Option** means a qualified benefit under Code §125(f) that is offered under this Cafeteria Plan, or an option for coverage under an underlying accident or health plan.

**Cafeteria Plan** means the State of Missouri Cafeteria Plan as set forth herein and as amended from time to time.

**Claims Administrator** means Application Software, Inc., dba ASI, dba ASIFlex.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**Code** means the Internal Revenue Code of 1986, as amended.

**Compensation** means the wages or salary paid to an Employee by the Employer, determined prior to: any Salary Reduction election under this Plan; any Salary Reduction election under any other cafeteria plan; any compensation reduction under any Code §132(f)(4) plan; and any salary deferral elections under any Code §§401(k), 408(k) or 457(b) Plan or arrangement.

**Contribution** means the amount contributed to pay for the cost of Benefits as calculated under the Benefit Options.

**DCAP** means Dependent Care Assistance Program.

**Dependent** means any individual who is a tax dependent of the Participant as defined in Code §§105(b) and 152, with the following exceptions:

- For purposes of accident or health coverage (to the extent funded under the PPP, and for purposes of the Health FSA:
  - A dependent is defined as in Code §§105(b) and 152, determined without regard to §152 subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and
  - Any child whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year) is treated as a dependent of both parents; and
- For purposes of the DCAP, a dependent means a Qualifying Individual.

Notwithstanding the foregoing, the Health FSA Component will provide Benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

**Dependent Care Assistance Program** means the dependent care assistance program component established by Employer under the Plan. It allows the Participant to use pre-tax dollars to pay for the care of the Participant's eligible Dependents while the Participant is at work.

**Dependent Care Expenses** has the meaning described in the DCAP Schedule below.

**Earned Income** means all income derived from wages, salaries, tips, self-employment, and other compensation (such as disability or wage continuation Benefits), but only if such amounts are includible in gross income for the taxable year. Earned income does not include: any amounts received pursuant to any DCAP established under Code §129; or any other amounts excluded from earned income under Code §32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

**Effective Date** of this Plan shall be January 1, 2011.

**Employee** means any person employed by the employer.

The following classes of employees cannot participate in the State of Missouri Cafeteria Plan:

- Leased employees (as defined by §414 (n) of the Code);
- Contract workers and independent contractors; and
- Individuals paid by a temporary or other employment or staffing agency.

**Employer** means State of Missouri including any agency, or department of the State of Missouri other than the University of Missouri and Southeast Missouri State University.

**ERISA** means the Employee Retirement Income Security Act of 1974, as amended.

**FMLA** means the Family and Medical Leave Act of 1993, as amended.

**HDHP** means High Deductible Health Plan.

**Health Care Expenses** has the meaning defined in the Health FSA Schedule below.

**Health Flexible Spending Account** means the health flexible spending account component established by the Employer under the Plan. It allows a Participant to use pre-tax dollars to pay for most health and dental expenses not reimbursed under other programs.

**Health FSA** means Health Flexible Spending Account.

**Health Plan** means the health benefit plan sponsored by the Employer.

**Health Savings Account** means the savings account Benefit Option established by the Employer's designee under this Plan.

**High Deductible Health Plan** means the high deductible health plan offered by the Employer that is intended to qualify as a high deductible health plan under Code §223(c)(2), as described in materials provided separately by the Employer.

**HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as amended.

**HSA** means a Health Savings Account established under Code §223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee/custodian.

**HSA Contribution Benefit** means the election to allow an Employee to receive HSA Contributions on a pre-tax, Salary Reduction basis and such Employer Contributions are excludable from the HSA Employee's income.

**HSA Employee** means an Employee covered under a qualifying High Deductible Health Plan (HDHP) (as defined by IRC §223). In order to receive Employer HSA Contribution Benefit, the Employee must certify that he or she: cannot be claimed as another person's tax dependent; is not entitled to Medicare Benefits, and does not have any health coverage other than HDHP coverage.

**Office of Administration** means the Office of Administration of the State of Missouri.

**Open Enrollment Period** with respect to a Plan Year means a period as described by the Plan Administrator preceding the Plan Year during which Participants may make Benefit elections for the Plan Year.

**Participant** means a person who is an Employee and who is participating in this Plan in accordance with the provisions of the Eligibility and Participation Section. Participants include: (a) those that elect to receive Benefits under this Plan, and enroll for Salary Reductions to pay for such Benefits; and (b) those that elect instead to receive their full salary in cash and have not elected the Health FSA or DCAP.

**Period of Coverage** means the Plan Year, with the following exceptions: for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in the Eligibility and Participation Section; and for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in the Eligibility and Participation Section.

**PHI** means Protected Health Information.

**Plan** means the State of Missouri Cafeteria Plan, as set forth herein and as amended from time to time.

**Plan Administrator** means the Office of Administration of its duly appointed designee to administer this Cafeteria Plan.

**Plan Year** means the twelve-month period ending December 31.

**PPP** means the Premium Payment Plan.

**Premium Payment Plan** means the Benefit Option in which an Employee can elect to participate and have Contributions for the Health Plan paid on a pre-tax basis.

**Protected Health Information (PHI)** means information that is created or received by State of Missouri Cafeteria Plan and relates to the past, present, or future physical, mental health or condition of a Participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. Protected health information includes information of persons living or deceased.

**QMCSO** means a Qualified Medical Child Support Order, as defined in ERISA §609(a).

**Qualifying Dependent Care Services** has the meaning described in the DCAP Schedule below.

**Qualifying Individual** means:

- A tax dependent of the Participant as defined in Code §152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code § 152(a)(1);
- A tax dependent of the Participant as defined in Code §152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or
- A Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child shall, as provided in Code §21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code §152(e)) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

**Related Employer** means any employer affiliated with State of Missouri that, under Code §414(b), (c), or (m), is treated as a single employer with State of Missouri for purposes of Code §125(g)(4), and which is listed in Appendix B.

**Salary Reduction** means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefit Options.

**Salary Reduction Agreement** means the agreement, form(s) or Internet web site, which Employees use to elect one or more Benefit Options. The agreement, forms and/or Internet web site spell out the procedures used for allowing an Employee to participate in this Plan and will allow the Employee to elect Salary Reductions to pay for any Benefit Options offered under this Plan.

**Spouse** means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a Spouse under the Code). Notwithstanding the above, for purposes of the DCAP, the term "Spouse" shall not include: an individual legally separated from the Participant under a divorce or separate maintenance decree; or an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from

**the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.**

**Student means an individual who, during five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly held.**

**USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.**

**Waive coverage means to formally opt-out of participation in the PPP in writing or online.**

<p style="text-align: center;"><b>Appendix A</b> <b>Exclusions—Medical Expenses That Are Not Reimbursable From the Health FSA</b></p>
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The Plan Document contains the general rules governing what expenses are reimbursable under the Health FSA. This Appendix A, as referenced in the Plan Document, specifies certain expenses that are excluded under this Plan with respect to reimbursement from the Health FSA -- that is, expenses that are *not* reimbursable, even if such expenses meet the definition of "medical care" under Code §§213(d) and 106(f) and may otherwise be reimbursable under the regulations governing health flexible spending accounts:

- Health insurance premiums for any other plan (including a plan sponsored by the Employer).
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).
- Custodial care.
- Costs for sending a problem child to a special school for Benefits that the child may receive from the course of study and disciplinary methods.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Over-the-counter medications and drugs, excluding insulin, without proof of a valid prescription.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.

- **Any item that does not constitute “medical care” as defined under Code §§213(d) and 106(f).**
- **Any item that is not reimbursable under Code §§213(d) and 106(f) due to the rules in Prop. Treas. Reg. §1.125-2, Q-7(b)(4) or other applicable regulations.**

**Appendix B**  
**Related Employers That Have Adopted This Plan**

With the Approval of State of Missouri.

The following Related Employers have adopted this plan:

- The Office of Administration
- The Department of Agriculture
- The Department of Conservation
- The Department of Corrections
- The Department of Economic Development
- The Department of Elementary and Secondary Education
- The Department of Health and Senior Services
- The Department of Higher Education
- The Department of Insurance, Financial Institutions and Professional Registration
- The Department of Labor and Industrial Relations
- The Department of Mental Health
- The Department of Natural Resources
- The Department of Public Safety
- The Department of Revenue
- The Department of Social Services
- The Department of Transportation
- The Office of the Attorney General
- The Office of the Governor
- The Office of the Lieutenant Governor
- The Office of the State Auditor
- The Office of the Secretary of State
- The Office of the Treasurer
- The Missouri House of Representatives
- The Missouri Senate
- The Missouri Consolidated Health Care Plan
- The Missouri State Employees' Retirement System
- The Supreme Court
- Harris-Stowe State University Board of Regents
- Lincoln University Board of Curators
- Missouri State University
- Northwest Missouri State University Board of Regents
- Truman State University Board of Governors
- University of Central Missouri Board of Governors

Employer means State of Missouri including any agency, or department of the State of Missouri other than the University of Missouri and Southeast Missouri State University.



**Schedule A  
Premium Payment Plan**

Unless otherwise specified, terms capitalized in this Schedule A shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

**A.1 Benefits**

If the Employee is an enrolled participant in the Health Plan and timely submits an executed Salary Reduction Agreement, the Employee can either:

- Option A: Elect Benefits under the PPP by electing to contribute his or her share for the Health Plan on a pre-tax basis; or
- Option B: Elect no Benefits under the PPP and to contribute his or her share, if any, for the Health Plan with after-tax deductions outside of this Plan.

If the Employee is an enrolled participant in the Health Plan and/or deduction plans of the Voluntary Payroll Vendors and does not timely submit an executed Salary Reduction Agreement, the Employee will be deemed to have elected Option A.

Benefits elected under Option A will be funded by the Participant's Contributions as provided in the Eligibility and Participation section in the Plan Document.

To determine when a Salary Reduction Agreement will be considered timely submitted, see the Method and Timing of Elections section in the Plan Document.

Unless an exception applies, as described in the Irrevocability of Elections and Exceptions section in the Plan Document, such election is irrevocable for the duration of the Period of Coverage to which it relates.

**A.2 Benefit Contributions**

The annual Contribution for the PPP is equal to the amount as set by the Employer, which may or may not be the same amount charged under the Health Plans.

**A.3 Medical Benefits Provided Under the Health Plans**

Medical benefits will be provided by the Health Plans, not this Plan. The types and amounts of medical benefits, the requirements for participation, and other terms and conditions of coverage and benefits of the Health Plans are set forth in the documents relating to that plan. No changes can be made under this Plan with respect to such Health Plans if such changes are not permitted under the applicable Health Plans.

All claims to receive benefits under the Health Plans shall be subject to and governed by the terms and conditions of the Health Plans and the rules, regulations, policies and procedures adopted in accordance therewith, as may be amended from time to time.

**A.4 COBRA**

To the extent required by COBRA, the Participant, Spouse and Dependent, as applicable, whose coverage terminates under the Health Plan because of a COBRA qualifying event and who is a qualified beneficiary as defined under COBRA, shall be given the opportunity to continue the same coverage that the Participant, Spouse or Dependent had under the Health Plan the day before the qualifying event for the periods prescribed by COBRA, on a self-pay basis. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

**A.5 Deduction Plans Provided Under the Voluntary Payroll Vendors**

Voluntary payroll vendors must qualify for inclusion in this Plan under rules set forth in 1 CSR 10-15.010 and 1 CSR 10-4.010 in order for the vendors' products to be included within this Plan.

Deduction plans provided by the Voluntary Payroll Vendors are offered by such vendors, not this Plan. The types and amounts of benefits, the requirements for participation, and other terms and conditions of coverage and benefits of the plans provided by the Voluntary Payroll Vendors are set forth in the documents relating to those plans. No changes can be made under this Plan with respect to such plans if such changes are not permitted under the applicable plans. In addition, no changes may also be made under this Plan unless such changes are permitted by this Plan.

All claims to receive benefits under the plans provided by the Voluntary Payroll Vendors shall be subject to and governed by the terms and conditions of such plans and the rules, regulations, policies and procedures adopted in accordance therewith, as may be amended from time to time.

**Schedule B**  
**Health Flexible Spending Account**

Unless otherwise specified, terms capitalized in this Schedule B shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

**B.1 Benefits**

An Employee not enrolled in the HSA Contribution Benefit, can elect to participate in the Health FSA by electing to receive Benefits in the form of reimbursements for Health Care Expenses. If elected, the Benefit Option will be funded by Participant Contributions on a pre-tax Salary Reduction basis as provided in the Employer and Participant Contributions section in the Plan Document.

Unless an exception applies as described in the Irrevocability of Elections and Exceptions section, such election is irrevocable for the duration of the Period of Coverage to which it relates.

The HSA Contribution Benefit cannot be elected with the Health FSA. In addition, a Participant who has an election for the Health FSA that is in effect on the last day of a Plan Year cannot elect the HSA Contribution Benefit for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's Health FSA is \$0 as of the last day of that Plan Year. For this purpose, a Participant's Health FSA balance is determined on a cash basis – that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

**B.2 Benefit Contributions**

The annual Contribution for a Participant's Health FSA is equal to the annual Benefit amount elected by the Participant.

**B.3 Eligible Health Care Expenses**

Under the Health FSA, a Participant may receive reimbursement for Health Care Expenses incurred during the Period of Coverage for which an election is in force.

- **Incurred.** A Health Care Expense is incurred at the time the medical care or service giving rise to the expense is provided, and not when the Participant is formally billed for, is charged for, or pays for the medical care.
- **Health Care Expenses.** Health Care Expenses means expenses incurred by a Participant, or the Participant's Spouse or Dependent(s) covered under the Health FSA for medical care, as defined in Code §§213(d) and 106(f), other than expenses that are excluded by this Plan, but only to the extent that the Participant or other person incurring the expense is not reimbursed through any other accident or health plan.
- **Expenses That Are Not Reimbursable.** Insurance premiums are not reimbursable from the Health FSA. Other expenses that are not reimbursable are listed in Appendix A to the Plan Document.

**B.4 Maximum and Minimum Benefits**

- **Maximum Reimbursement Available; Uniform Coverage Rule.** The maximum dollar amount elected by the Participant for reimbursement of Health Care Expenses incurred during a Period of Coverage, reduced by prior reimbursements during the Period of Coverage, shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health FSA. Notwithstanding the foregoing, no reimbursements will be available for Health Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided below.
- **Payment shall be made to the Participant in cash as reimbursement for Health Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Section have been satisfied.**
- **Maximum Dollar Limit.** The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Health Care Expenses incurred in any Period of Coverage shall be the lesser of \$5,000.00 or the maximum allowed under federal regulations. Reimbursements due for Health Care Expenses incurred by the Participant's Spouse or Dependent(s) shall be charged against the Participant's Health FSA.
- **Changes.** For subsequent Plan Years, the maximum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Salary Reduction Agreement or another document.
- **No Proration.** If a Participant enters the Plan mid-year or wishes to increase his or her election mid-year as permitted under this Plan, then the Participant may elect coverage or increase coverage respectively, up to the maximum annual benefit amount stated above. The maximum annual benefit amount will not be prorated.
- **Effect on Maximum Benefits If Election Change Permitted.** Any change in an election affecting annual Contributions to the Health FSA will also change the maximum reimbursement benefits for the balance of the Period of Coverage commencing on the election change effective date. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding:
  - The aggregate Contribution for the period prior to such election change; to
  - The total Contribution for the remainder of such Period of Coverage to the Health FSA; reduced by
  - All reimbursements made during the entire Period of Coverage.
- **FMLA Leave.** Any change in an election for FMLA leave will change the maximum reimbursement benefits in accordance with FMLA or the regulations governing cafeteria plans.
- **Monthly Limits on Reimbursing OTC Drugs.** Only reasonable quantities of over-the-counter (OTC) drugs or medicines of the same kind may be reimbursed from a Participant's Health FSA in a single calendar month, even assuming that the drug otherwise meets the requirements of

this Section, including that it is for medical care under Code §§213(d) and 106(f). Stockpiling is not permitted.

**B.5 Establishment of Account**

The Plan Administrator will establish and maintain a Health FSA with respect to each Participant who has elected to participate in the Health FSA, but will not create a separate fund or otherwise segregate assets for this purpose. The account established hereto will merely be a record keeping account with the purpose of keeping track of Contributions and determining forfeitures.

- **Crediting of Accounts.** A Participant's Health FSA will be credited following each Salary Reduction actually made during each Period of Coverage with an amount equal to the Salary Reduction actually made.
- **Debiting of Accounts.** A Participant's Health FSA will be debited during each Period of Coverage for any reimbursement of Health Care Expenses incurred during the Period of Coverage.
- **Available Amount Not Based on Credited Amount.** The amount available for reimbursement of Health Care Expenses is the amount as calculated according to the "Maximum Reimbursement Available" paragraph of this Section above. It is not based on the amount credited to the Health FSA at a particular point in time.

**B.6 Use It or Lose It Rule; Forfeiture Of Account Balance**

- **Use It or Lose It Rule.** If any balance remains in the Participant's Health FSA for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Health Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. Claims must be submitted on or before April 15<sup>th</sup> of the year immediately following the close of the plan year in which the expenses were incurred.
- **Use of Forfeitures.** All forfeitures under this Plan shall be used as follows:
  - First, to offset any losses experienced by Employer during the Plan Year as a result of making reimbursements with respect to any Participant in excess of the Contributions paid by such Participant through Salary Reductions;
  - Second, to reduce the cost of administering the Health FSA during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and
  - To provide increased Benefits or compensation to all Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations.
- **Unclaimed Benefits.** Benefit payments that remain unclaimed by the close of the Plan Year following the Period of Coverage in which the Health Care Expense was incurred shall be forfeited and applied as described above.

**B.7 Reimbursement Procedure**

- **Timing.** Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Health Care Expenses, or the Plan Administrator will notify the Participant that a claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days from receipt of the written notice in which to complete an incomplete reimbursement claim.
- **Claims Substantiation.** A Participant who has elected to receive Health Care Reimbursement Benefits for a Period of Coverage may apply for reimbursement by submitting an application to the Plan Administrator by no later than the date set by the Plan Administrator each year, setting forth:
  - The person or persons on whose behalf Health Care Expenses have been incurred;
  - The nature and date of the expenses incurred;
  - The amount of the requested reimbursement;
  - A statement that such expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source; and
  - Other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Health Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Plan Administrator may request.

- **Claims Denied.** For appeal of claims that are denied, see the Appeals Procedure in the Plan Document.
- **Claims Ordering; No Reprocessing.** All claims for reimbursement will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized solely for the purpose of paying it from amounts attributable to a different Plan Year or Period of Coverage.

**B.8 Reimbursements After Termination; Limited COBRA Continuation**

The Participant will not be able to receive reimbursements for Health Care Expenses incurred after participation terminates. However, such Participant, or the Participant's estate, may claim reimbursement for any Health Care Expenses incurred during the Period of Coverage prior to termination, provided that the Participant, or the Participant's estate, files a claim by the date established in the Reimbursement Procedure paragraphs above following the close of the Plan Year in which the Health Care Expense was incurred.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and such Participant's Spouse and Dependent(s), whose coverage terminates under the Health FSA because of a COBRA qualifying event, shall be given the opportunity to continue the same coverage that the Participant had under the Health FSA the day before the qualifying event, subject to all conditions and limitations under COBRA. The Contributions for such continuation coverage will be equal to the cost of providing the same coverage to an active employee taking into account all costs incurred by the Employee and the Employer plus a 2% administration fee. Specifically, an individual will be eligible for COBRA continuation coverage only if the Participant's remaining available amount is greater than the Participant's remaining Contribution payments at the time of the qualifying event, taking into account all claims submitted before the date of the qualifying event. Such individual will be notified if the individual is eligible for COBRA continuation coverage.

If COBRA is elected, COBRA coverage will be subject to the most current COBRA rules. COBRA will be available only for the remainder of the Plan Year in which the qualifying event occurs. Such COBRA coverage for the Health FSA will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Coverage may terminate sooner if the Contributions for a Period of Coverage are not received by the due date established by the Plan Administrator for that Period of Coverage. Continuation coverage is only granted after the Plan Administrator has received the Contributions for that period of coverage.

Contributions for coverage for Health FSA Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation, as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from Contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year, where COBRA coverage arises either:

- Because the Employee ceases to be eligible because of a reduction of hours; or
- Because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage.

For all other individuals (for example, Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Health FSA Benefits shall be paid on an after-tax basis, unless permitted otherwise by the Plan Administrator, in its discretion and on a uniform and consistent basis, but may not be prepaid from Contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year.

#### **B.9 Qualified Reservist Distribution**

If a Participant meets all of the following conditions, the Participant may elect to receive a qualified reservist distribution from the Health FSA:

- The Participant's Contributions to the Health FSA for the Plan Year as of the date the qualified reservist distribution is requested exceeds the reimbursements the Participant has received from the Health FSA for the Plan Year as of that date.
- The Participant is ordered or called to active military duty for a period of at least 180 days or for an indefinite period by reason of being a member of the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air

National Guard of the United States, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.

- The Participant has provided the Plan Administrator with a copy of the order or call to active duty. An order or call to active duty of less than 180 days' duration must be supplemented by subsequent calls or orders to reach a total of 180 or more days.
- The Participant is ordered or called to active military duty on or after April 1, 2009, or the Participant's period of active duty begins before April 1, 2009 and continues on or after the date.
- During the period beginning on the date of the Participant's order or call to active duty and ending on the last day of the Plan Year during which the order or call occurred, the Participant submits a qualified reservist distribution election form to the Plan Administrator.

**Amount of Qualified Reservist Distribution.** If the above conditions are met, the Participant will receive a distribution from the Health FSA equal to his or her Contributions to the Health FSA for the Plan Year as of the date of the distribution request, minus any reimbursements received for the Plan Year as of that date.

**No Reimbursement for Expenses Incurred After Distribution Request.** Once a Participant requests a qualified reservist distribution, the Participant forfeits the right to receive reimbursements for Health Care Expenses incurred during the period that begins on the date of the distribution request and ends on the last day of the Plan Year. The Participant may, however, continue to submit claims for Health Care Expenses that were incurred before the date of the distribution request (even if the claims are submitted after the date of the qualified reservist distribution), so long as the total dollar amount of the claims does not exceed the amount of the Health FSA election for the Plan Year, minus the sum of the qualified reservist distribution and the prior Health FSA reimbursements for the Plan Year.

**Tax Treatment of a Qualified Reservist Distribution.** If the Participant receives a qualified reservist distribution, it will be included in his or her gross income and will be reported as wages on the Participant's Form W-2 for the year in which it is paid.

#### **B.10 Named Fiduciary**

The Plan Administrator is the Named Fiduciary for the Health FSA.

#### **B.11 Coordination of Benefits**

Health FSAs are intended to pay Benefits solely for Health Care Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the Health FSA shall not be considered a group health plan for coordination of benefits purposes, and the Health FSA shall not be taken into account when determining benefits payable under any other plan.



**Schedule C**  
**HSA Contribution Benefit**

Unless otherwise specified, terms capitalized in this Schedule C shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

**C.1 HSA Tax Advantages**

An Employee may elect to participate in the HSA Contribution Benefit by electing to pay the Contributions on a pre-tax Salary Reduction basis to the Employee's Health Savings Account (HSA) established and maintained outside the Plan by a trustee/custodian to which the Employer can forward Contributions to be deposited. This funding feature constitutes the HSA Contribution Benefit.

As described more fully herein, such election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed.

**C.2 Establishing an HSA**

For administrative convenience, the Employer may chose to make Contributions for Employees to HSAs established at a bank selected by the Employer or limit the number of HSA providers to whom it will forward Contributions-such a list is not an endorsement of any HSA provider. The selected bank will be an authorized HSA trustee. The forms necessary to establish an HSA at the selected bank will be provided to Participants. Participants are responsible for managing their own HSA, including choosing how HSA funds are invested and following the rules of the selected bank and the IRS. Once the Employer Contributions have been deposited in a Participant's HSA Contribution Benefit, the Participant has a non-forfeitable interest in the funds and is free to request a distribution of the funds or to move them to another HSA provider, to the extent permitted by law.

The HSA Contribution Benefit cannot be elected with the Health FSA. In addition, a Participant who has an election for the Health FSA that is in effect on the last day of a Plan Year cannot elect the HSA Contribution Benefit for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's Health FSA is \$0 as of the last day of the Plan Year. For this purpose, a Participant's Health FSA balance is determined on a cash basis -- that is, without regard to claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

**C.3 Certification of HSA Contribution Benefit Eligibility**

To be eligible for the HSA Contribution Benefit, an HSA Employee must certify to the Employer that he or she is eligible for an HSA contribution and does not have any non-HDHP coverage. A married Participant must also certify that his or her Spouse does not have any non-HDHP coverage. A Participant is required to notify the Employer immediately if there are any changes in the information contained in the certification. Failure to provide accurate and updated information could cause the HSA Contribution Benefit to be included in a Participant's gross income and may also be subject to excise tax.

**C.4 Maximum Contribution**

The annual Contribution for a Participant's HSA Contribution Benefit is equal to the annual Benefit amount elected by the Participant. In no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the Participant's HDHP coverage option for the calendar year in which the Contribution is made (for calendar year 2011, \$3,050 for self-coverage or \$6,150 for family coverage).

Participants age 55 or older may make an additional catch-up Contribution of \$1,000 per year.

In addition, the maximum annual Contribution shall be:

- Reduced by any matching or other Employer Contribution made on the Participant's behalf; and
- Prorated for the number of months in which the Participant is an HSA Eligible Individual.

**C.5 Recording Contributions for HSA**

The Plan Administrator will maintain records to keep track of Contributions an Employee makes via pre-tax Salary Reductions to his or her HSA, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

**C.6 Distributions from HSA Contribution Benefit**

Distribution from an HSA Contribution Benefit will be tax-free if the distribution is for expenses incurred for a Participant's health care as defined in IRC §213(d) or the health care of a Participant's legal Spouse or tax Dependents. Expenses must have been incurred after the establishment of the HSA Contribution Benefit to be tax-free. HSA Contribution Benefit distributions used to pay insurance premiums will not be tax-free unless they are used for COBRA coverage, qualified long-term care insurance, health insurance maintained while the individual is receiving unemployment compensation under federal or state law, or health insurance for an individual age 65 or over, other than a Medicare supplemental policy.

**C.7 Tax Treatment of HSA Contributions and Distributions**

The tax treatment of the HSA is governed by Code §223.

**C.8 Reporting Issues**

Each Participant will be responsible for reporting Contributions made to his or her HSA Contribution Benefit and for reporting distributions from the HSA. A Participant is also responsible for reporting whether or not HSA distributions were used for qualified health expenses or whether the distributions were taxable. A Participant should maintain records sufficient to demonstrate whether or not distributions were taxable.

**C.9 Voluntary Participation**

Participation in the HSA Contribution Benefit is entirely voluntary and may be terminated at any time by notifying the Employer. Although the Employer expects to continue this HSA Contribution Benefit indefinitely, it has the right to amend or terminate HSA Contribution Benefit at any time and for any reason. It is also possible that changes to the program will be necessary or advisable as a result of future changes in state or federal tax laws.

**C.10 HSA Not Intended to be an ERISA Plan**

The HSA Contribution Benefit under this Plan consist solely of the ability to make Contributions to the HSA on a pre-tax Salary Reduction basis. Terms and conditions of coverage and Benefits will be provided by and are set forth in the HSA, not this Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan.

The HSA is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible health expenses" as set forth in Code §223(d)(2). The Employer has no authority or control over the funds deposited in a HSA. Even though this Plan may allow pre-tax Salary Reduction contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

**Schedule D**  
**Dependent Care Assistance Program**

Unless otherwise specified, terms capitalized in this Schedule D shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

**D.1 Benefits**

An Employee can elect to participate in the DCAP to receive Benefits in the form of reimbursements for Dependent Care Expenses. If elected, the Benefit Option will be funded by the Participant on a pre-tax Salary Reduction basis. Unless an exception applies, as described in the Irrevocability of Elections and Exceptions section above, such election is irrevocable for the duration of the Period of Coverage to which it relates.

**D.2 Benefit Contributions**

The annual Contribution for a Participant's DCAP Benefits is equal to the annual Benefit amount elected by the Participant, subject to the Maximum Benefits paragraph below.

**D.3 Eligible Dependent Care Expenses**

Under the DCAP, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

- **Incurred.** A Dependent Care Expense is "incurred" at the time the Qualifying Dependent Care Service giving rise to the expense is provided, and not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services.
- **Dependent Care Expenses.** Dependent Care Expenses means expenses that are considered to be:
  - Employment-related expenses under Code §21(b)(2) relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse; and
  - Expenses for incidental household services, if incurred by the Employee to obtain Qualifying Dependent Care Services, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through any other Plan.

If only a portion of a Dependent Care Expense has been reimbursed elsewhere, the DCAP can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Schedule.

- **Qualifying Individual.** A Qualifying Individual is:
  - A tax dependent of the Participant as defined in Code §152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code §152(a)(1);

- A tax dependent of the Participant as defined in Code §152, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or
- A Participant's Spouse, as defined in Code §152, who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

In the case of divorced or separated parents, a child shall be treated as a Qualifying Individual of the custodial parent within the meaning of Code §152(e).

- **Qualifying Dependent Care Services.** Qualifying Dependent Care Services means services that both:
  - Relate to the care of a Qualifying Individual that enable the Participant and Spouse to remain gainfully employed after the date of participation in the DCAP and during the Period of Coverage; and
  - Are performed:
    - In the Participant's home; or
    - Outside the Participant's home for:
      - The care of a Participant's Dependent who is under age 13; or
      - The care of any other Qualifying Individual who regularly spends at least 8 hours per day in the Participant's household.

In addition, if the expenses are incurred for services provided by a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment or grant for such services, then the facility must comply with all applicable state and local laws and regulations.

- **Exclusions.** Dependent Care Expenses do not include amounts paid to or for:
  - An individual with respect to whom a personal exemption is allowable under Code §151(c) to a Participant or Participant's Spouse;
  - A Participant's Spouse;
  - A Participant's child, as defined in Code §152(f)(1), who is under 19 years of age at the end of the year in which the expenses were incurred; and
  - A Participant's Spouse's child, as defined in Code §152 (a)(i), who is under 19 years of age at the end of the year in which the expenses were incurred.

**D.4 Maximum Benefit**

- **Maximum Reimbursement Available and Statutory Limits.** The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's DCAP less amounts debited to the Participant's DCAP pursuant to the Maximum Contribution paragraph below.

Payment shall be made to the Participant as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Section have been satisfied.

No reimbursement otherwise due to a Participant hereunder shall be made to the extent that such reimbursement, when combined with the total amount of reimbursements made to date for the Plan Year, would exceed the year to date amount of Participant Contributions to the DCAP for the Period of Coverage or applicable statutory limit.

- **Maximum Dollar Limit.** The maximum dollar limit for a Participant is the smallest of the following amounts:
  - The Participant's Earned Income for the calendar year;
  - The Earned Income for the calendar year of the Participant's Spouse who:
    - Is not employed during a month in which the Participant incurs a Dependent Care Expense; and
    - Is either physically or mentally incapable of self-care or a full-time Student shall be deemed to have Earned Income in the amount of \$250 per month per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount of \$500 per month); or
  - \$5,000 for the calendar year or the maximum allowed under federal regulations, if:
    - The Participant is married and files a joint federal income tax return; or
    - The Participant is married, files a separate federal income tax return, and meets the following conditions:
      - The Participant maintains as his or her home a household that constitutes, for more than half of the taxable year, the principal abode of a Qualifying Individual;
      - The Participant furnishes over half of the cost of maintaining such household during the taxable year; and
      - During the last six months of the taxable year, the Participant's Spouse is not a member of such household; or

- The Participant is single or is the head of the household for federal income tax purposes.
- \$2,500 for the calendar year, or the maximum allowed under federal regulation, if the Participant is married and resides with the Spouse, but files a separate federal income tax return.
- **Changes.** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Salary Reduction Agreement or another document.
- **No Proration.** If a Participant enters the Plan mid-year or wishes to increase his or her election mid-year as permitted under this Plan, then the Participant may elect coverage or increase coverage respectively, up to the maximum annual benefit amount stated above. The maximum annual benefit amount will not be prorated.
- **Effect on Maximum Benefits If Election Change Permitted.** Any change in an election affecting annual Contributions to the DCAP component will also change the maximum reimbursement Benefits for the balance of the Period of Coverage commencing with the election change effective date. Such maximum reimbursement Benefits for the balance of the Period of Coverage shall be calculated by adding:
  - The aggregate Contribution for the period prior to such election change; to
  - The total Contribution for the remainder of such Period of Coverage to the DCAP; reduced by
  - All reimbursements made during the entire Period of Coverage.

#### **D.5 Establishment of Account**

The Plan Administrator will establish and maintain a DCAP with respect to each Participant who has elected to participate in the DCAP, but will not create a separate fund or otherwise segregate assets for this purpose. The account so established will merely be a record keeping account with the purpose of keeping track of Contributions and determining forfeitures.

- **Crediting of Accounts.** A Participant's DCAP will be credited following each Salary Reduction actually made during each Period of Coverage with an amount equal to the Salary Reduction actually made.
- **Debiting of Accounts.** A Participant's DCAP will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.
- **Available Amount is Based on Credited Amount.** The amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCAP, less any prior reimbursements. A Participant's DCAP may not have a negative balance during a Period of Coverage.

**D.6 Unused Year End Balance**

- **Use It or Lose It Rule.** If any balance remains in the Participant's DCAP after all reimbursements have been made for the Period of Coverage, it shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during the subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. Claims must be submitted on or before April 15<sup>th</sup> of the year immediately following the close of the plan year in which the expenses were incurred.
- **Use of Forfeiture.** All forfeitures shall be used by the Plan in the following ways:
  - To offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements with respect to all Participants in excess of the Contributions paid by such Participant through Salary Reduction;
  - To reduce the cost of administering the DCAP during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and
  - To provide increased Benefits or Compensation to Participants in subsequent years in any weighted or uniform fashion the Plan Administrator deems appropriate, and consistent with applicable regulations.
- **Unclaimed Benefits.** Any DCAP Benefit payments that are unclaimed by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be applied as described above.

**D.7 Reimbursement Procedure**

- **Timing.** Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses or the Plan Administrator will notify the Participant that a claim has been denied. This time period may be extended an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days from receipt of the written notice in which to complete an incomplete reimbursement claim.
- **Claims Substantiation.** A Participant who has elected to receive DCAP Benefits for a Period of Coverage may apply for reimbursement by completing, signing, and returning an application to the Plan Administrator by no later than the date set by the Plan Administrator each year, setting forth:
  - The person or persons on whose behalf Dependent Care Expenses have been incurred;
  - The nature and date of the expenses incurred;
  - The amount of the requested reimbursement;
  - The name of the person, organization or entity to whom the expense was or is to be paid;



- A statement that such expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source;
- The Participant's certification that he or she has no reason to believe that the reimbursement refunded, added to other reimbursements to date will exceed the limit herein; and
- Other such details about the expenses that may be requested by the Plan Administrator.

The Participant shall include bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Plan Administrator may request.

- **Claims Denied.** For appeals of claims that are denied, see the Appeals Procedure in the Plan Document.

#### **D.8 Reimbursements After Termination**

If a Participant's employment terminates, the Participant may submit for reimbursement Dependent Care Expenses incurred after the date of termination up to the amount of the Participant's remaining DCAP Benefits.

#### **D.9 DCAP Participant vs. Claiming the Dependent Care Tax Credit**

Employees often have the choice between participating in their employer's DCAP on a Salary Reduction basis or taking a Dependent Care Tax Credit under Code §21. Employees cannot take advantage of both tax benefit options. Employees with questions regarding which option is best should consult with an accountant.

**AUTHORITY:** section 33.103, RSMo Supp. [2007] 2010. Original rule filed March 15, 1988, effective June 1, 1988. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Dec. 21, 2010, effective Jan. 1, 2011, expires June 29, 2011. Amended: Filed Dec. 21, 2010.

**PUBLIC COST:** This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

**PRIVATE COST:** The proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed amendment with Office of Administration, Division of Accounting, Mark A. Kaiser, Director, PO Box 809, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

## **Title 2—DEPARTMENT OF AGRICULTURE**

### **Division 30—Animal Health**

### **Chapter 6—Livestock Markets**

#### **PROPOSED AMENDMENT**

**2 CSR 30-6.020 Duties and Facilities of the Market/Sale Veterinarian.** The director is amending section (3), deleting section (9), amending and renumbering section (10), and renumbering sections (11) and (12).

**PURPOSE:** This amendment establishes *Trichomoniasis* requirements for non-virgin bulls or bulls twenty-four (24) months of age or older exchanged, bartered, sold, leased, or relinquished at a licensed livestock market/sale and deletion of duplicate section of poultry.

(3) Cattle, Bison, and Exotic Bovids.

(B) Brucellosis Requirements.

1. [The market/sale veterinarian must obtain required blood samples on all test-eligible animals (bulls, heifers, and cows eighteen (18) months of age and over) for brucellosis and submit those samples to the Cooperative State and Federal Veterinary Diagnostic Laboratory in Jefferson City for testing required by the Animal Health laws and rules pertaining to disease control. This includes animals consigned to slaughter and feedlots as well as those that might return to farms as breeding stock.] An official bangle tag may serve as identification for a health certificate for intrastate movement, provided the following information is shown on the tag:

- A. Date of test;
- B. Complete official eartag number;
- C. Age of the animal; and
- D. State code letters of the testing veterinarian.

[2. A market/sale veterinarian may recognize a brucellosis test performed within the last five (5) working days if proper health certificates accompany the animal(s). An official bangle tag may serve as a health certificate for intrastate movement, provided the following information is shown on the tag:

- A. Date of test;
- B. Complete official eartag number;
- C. Age of the animal; and
- D. State code letters of the testing veterinarian.]

(D) *Trichomoniasis* Requirements.

1. All breeding bulls (excluding exotic bovines) prior to entering [to] a licensed market shall be—

A. Virgin bulls not more than twenty-four (24) months of age as determined by the presence of both permanent central incisor teeth in wear or by breed registry papers; or

B. Be tested negative for *Trichomoniasis* with an official culture test or official Polymerase Chain Reaction (PCR) test by an approved diagnostic laboratory within thirty (30) days prior to entry into the state.

(I) Bulls shall be tested three (3) times not less than one (1) week apart by an official culture test or one (1) time by official PCR test prior to entering Missouri.

(II) Bulls shall be identified by official identification at the time the initial test sample is collected.

(III) Bulls that have had contact with female cattle subsequent to testing must be retested prior to entry.

2. If the breeding bulls are virgin bulls, less than twenty-four (24) months of age, they shall be—

A. Individually identified by official identification; and

B. Be accompanied with a breeder's certification of virgin status signed by the breeder or his representative attesting that they are virgin bulls.

C. The official identification number shall be written on the breeder's certificate.

**3. Non-virgin or bulls twenty-four (24) months of age or older must be *Trichomoniasis* tested with three (3) culture or one (1) PCR test. Bulls may be quarantined at farm pending test results. If test results are positive, the positive animal and cohorts will be place under quarantine.**

[3.]4. A Certificate of Veterinary Inspection listing official identification and test performed, date of test, results, and laboratory, if testing is required.

[4.]5. Bulls going directly to slaughter are exempt from *Trichomoniasis* testing.

[(9) Poultry.

(A) Out-of-state live poultry (except those consigned directly to slaughter) shall be accompanied by an official Certificate of Veterinary Inspection or a VS Form 9-3 (see 2 CSR 30-2.040). If a VS Form 9-3 is used, a signed and dated owner/shipper statement must be included stating that to his/her best knowledge, the birds are healthy. Poultry known to be infected with pullorum or typhoid that are consigned directly to slaughter must be identified as such by the consignor.

(B) Out-of-state live poultry entering Missouri must be tested negative for pullorum-typhoid within the past ninety (90) days or originate from a flock approved by the National Poultry Improvement Plan (NPIP) or an equivalent program which has been tested within the past twelve (12) months with no change of ownership.

(C) All hatching eggs must be accompanied by an official Certificate of Veterinary Inspection certifying the eggs to be from pullorum-free flocks or by a VS Form 9-3.

(D) Out-of-state poultry and hatching eggs moving through a Missouri livestock market/sale require an entry permit prior to shipment. Annual entry permits shall be issued by the department to participants in the NPIP or an equivalent program. Producers not approved by NPIP or an equivalent program must request a permit with each shipment.]

[[10]](9) **Camelids**, Alpacas, Camels, and Llamas. Alpacas, camels, llamas, and others of that group exchanged, bartered, sold, leased, or relinquished at a licensed livestock market/sale in Missouri must be veterinarian inspected, accompanied by a Certificate of Veterinary Inspection showing an individual listing of the common and scientific name(s) of the animal(s) and appropriate description of animal(s) such as sex, age, weight, and coloration, and must be individually identified by an official eartag as defined in Title 9, *Code of Federal*

*Regulations*, Part 71, published annually in January, herein incorporated by reference and made a part of this rule, as published by the United States Superintendent of Documents, 732 N Capital Street NW, Washington, DC 20402-0001, phone: toll free (866) 512-1800, DC area (202) 512-1800, website <http://bookstore.gpo.gov>, microchip, or other method approved by the state veterinarian. This rule does not incorporate any subsequent amendments or additions.

~~/(11)/~~(10) Ratites (Including But Not Limited to Ostrich, Rheas, and Emus). All ratites must be veterinarian inspected, individually identified by official identification (leg band, microchip, wing band, legible tattoo, or any other means of permanent identification approved by the state veterinarian), and listed on a Certificate of Veterinary Inspection. In addition, ratites entering Missouri for sale at a licensed livestock/market must obtain an entry permit.

~~/(12)/~~(11) Miscellaneous and Exotic Animals. All exotic animals presented for exchange, barter, lease, or sale at a licensed livestock market/sale must be veterinarian inspected, individually identified by official identification (official eartag, brand, tattoo, or any other means of permanent identification approved by the state veterinarian), and accompanied by an official Certificate of Veterinary Inspection showing an individual listing of the common and scientific name(s) of the animal(s) and appropriate descriptions of animal(s) such as sex, age, weight, and coloration.

(A) Elephants (Asiatic, African) must be tested negative for tuberculosis within one (1) year prior to movement; test results must be noted on the Certificate of Veterinary Inspection.

(B) Importation of skunks and raccoons into Missouri is prohibited by the *Missouri Wildlife Code* (3 CSR 10-9).

*AUTHORITY: section 277.160, RSMo 2000. Original rule filed June 15, 1990, effective Dec. 31, 1990. For intervening history, please consult the Code of State Regulations. Amended: Filed Dec. 23, 2010.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment may cost private entities an estimated eight thousand seven hundred seventy-five dollars (\$8,775) dependent on the number of animals sold.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Agriculture, Taylor H. Woods, State Veterinarian, PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: Agriculture**  
**Division Title: Animal Health**  
**Chapter Title Title 2**

<b>Rule Number and Title:</b>	2 CSR 30-6.020 Duties and Facilities of the Market/Sale Veterinarian.
<b>Type of Rulemaking:</b>	Proposed

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>117 livestock market/sales and unknown number of producers</b>	<b>Livestock markets</b>	<b>\$8,775.00</b>

**III. WORKSHEET**

\$75 an animal x 117 markets = \$8,775.00

**IV. ASSUMPTIONS**

This proposed amendment requires any non-virgin or bulls twenty-four (24) months of age or older to be tested for Trichomoniasis that go through a livestock market/sale in Missouri or be sent to slaughter with no further testing. The number of animals involved is unknown.

For the producer to have the animal tested prior to arriving at the market, it would include (but not limited to): sample collection fee, possibly a trip fee that would vary on the distance from the vet clinic to the farm, postage charges, and a charge to complete a Certificate of Veterinary Inspection. Charges would vary from each veterinarian and the location throughout the state.

At the market, if the animal showed up with no test, the animal could be sent to slaughter with no further testing.

However, if the animal is purchased at the market, the market veterinarian would collect the sample for testing and the buyer would be responsible for (but not limited to) sample collection charge, sample testing, and a charge to complete a Certificate of Veterinary Inspection.

**Title 16—RETIREMENT SYSTEMS**  
**Division 50—The County Employees' Retirement Fund**  
**Chapter 10—County Employees' Defined Contribution Plan**

**PROPOSED AMENDMENT**

**16 CSR 50-10.010 Definitions.** The board is amending subsection (1)(J).

*PURPOSE:* This amendment clarifies the definition of Hour of Service.

(1) Whenever used in this Chapter 10, the following terms shall have the meanings as set forth in this rule 16 CSR 50-10.010 unless a different meaning is clearly required by the context:

(J) Hour of Service means each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer, **or each hour for which an Employee is otherwise credited during an absence for sickness and injury of less than twelve (12) months to the extent so certified on a form provided by the board or its designee to be on an approved leave of absence for medical reasons under the written policies of an Employer, or as required by the Family and Medical Leave Act of 1993, by the Uniformed Services Employment and Reemployment Rights Act of 1994, or other applicable law.**

*AUTHORITY:* sections 50.1000, RSMo Supp. [2009] **2010** and sections 50.1210-50.1260, RSMo 2000 and Supp. [2009] **2010**. Original rule filed May 9, 2000, effective Jan. 30, 2001. Amended: Filed April 25, 2002, effective Nov. 30, 2002. Amended: Filed Dec. 22, 2008, effective July 30, 2009. Amended: Filed Jan. 25, 2010, effective July 30, 2010. Amended: Filed Dec. 20, 2010.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the County Employees' Retirement Fund, 2121 Schotthill Woods Drive, Jefferson City, MO 65101. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 16—RETIREMENT SYSTEMS**  
**Division 50—The County Employees' Retirement Fund**  
**Chapter 10—County Employees' Defined Contribution Plan**

**PROPOSED AMENDMENT**

**16 CSR 50-10.030 Contributions.** The board is deleting subsection (3)(B), renumbering subsequent subsections, and amending subsection (5)(A).

*PURPOSE:* This amendment amends the participants eligible for a board matching contribution and clarifies the time for electing employer matching contributions.

(3) A Participant is a "Qualified Participant" for a Plan Year, if he or she is employed by an Employer and:

*[(B) Is on a leave of absence taken under the Family and Medical Leave Act of 1993 on the last day of the Plan Year*

*or, as of the last day of the Plan Year, is on an absence for sickness or injury of less than twelve (12) months, that is counted as Creditable Service under 16 CSR 50-5.030;]*

*[(C)](B) Dies during the Plan Year; or*

*[(D)](C) Retires during the Plan Year. "Retirement," for this purpose, means termination of employment after attainment of age sixty-two (62) after having become fully vested in accordance with rule 16 CSR 50-10.070.*

(5) Employer Matching Contributions. Each Employer, in its sole discretion, shall determine if it will make Employer matching contributions for any Plan Year beginning after December 31, 2001.

(A) An Employer may elect, before or as soon as possible ~~/before/~~ after the beginning of each Plan Year, to make Employer matching contributions for the Plan Year by transmitting minutes of the meeting of the county commission or other governing body at which Employer matching contributions are authorized for such Plan Year to the Board within thirty (30) days of such meeting. Any such election shall not apply to subsequent Plan Years.

*AUTHORITY:* sections 50.1220 and 50.1260, RSMo 2000 and 50.1230 and 50.1250, RSMo Supp. [2008] **2010**. Original rule filed May 9, 2000, effective Jan. 30, 2001. Amended: Filed April 25, 2002, effective Nov. 30, 2002. Amended: Filed Sept. 10, 2002, effective April 30, 2003. Amended: Filed Nov. 10, 2005, effective May 30, 2006. Amended: Filed Sept. 17, 2007, effective March 30, 2008. Amended: Filed Dec. 22, 2008, effective July 30, 2009. Amended: Filed Dec. 20, 2010.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the County Employees' Retirement Fund, 2121 Schotthill Woods Drive, Jefferson City, MO 65101. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 16—RETIREMENT SYSTEMS**  
**Division 50—The County Employees' Retirement Fund**  
**Chapter 10—County Employees' Defined Contribution Plan**

**PROPOSED AMENDMENT**

**16 CSR 50-10.070 Vesting and Service.** The board is amending subsection (3)(A).

*PURPOSE:* This amendment clarifies the determination of years of service.

(3) The following periods do not constitute Years of Service, regardless of any provision in this rule 16 CSR 50-10.070 to the contrary:

(A) A Plan Year beginning on or after January 1, 2000, in which an Employee earns less than 1,000 Hours of Service, *unless the failure to earn such Hours of Service was the result of a leave described in the Family and Medical Leave Act of 1993;* and

*AUTHORITY:* sections 50.1090, RSMo 2000 and 50.1250, RSMo Supp. [2003] **2010**. Original rule filed May 9, 2000, effective Jan. 30, 2001. Amended: Filed April 25, 2002, effective Nov. 30, 2002.

*Amended: Filed July 13, 2004, effective Jan. 30, 2005. Amended: Filed Dec. 20, 2010.*

**PUBLIC COST:** *This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

**PRIVATE COST:** *This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

**NOTICE TO SUBMIT COMMENTS:** *Anyone may file a statement in support of or in opposition to this proposed amendment with the County Employees' Retirement Fund, 2121 Schotthill Woods Drive, Jefferson City, MO 65101. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 16—RETIREMENT SYSTEMS**  
**Division 50—The County Employees' Retirement Fund**  
**Chapter 10—County Employees' Defined Contribution Plan**

**PROPOSED AMENDMENT**

**16 CSR 50-10.080 Plan Administration.** The board is amending section (5).

**PURPOSE:** *This amendment clarifies claim procedures.*

(5) Claims for Benefits. A claim for a benefit under this Plan shall be reviewed by the Board (or by its designee) in accordance with the *[procedure outlined in 16 CSR 50-1.015]* **procedures established by the Board or such designee.** An appeal of an adverse claim decision shall be processed in accordance with 16 CSR 50-1.020.

**AUTHORITY:** *sections 50.1010, RSMo [1994] Supp. 2010 and 50.1240, RSMo [Supp. 1999] 2000. Original rule filed May 9, 2000, effective Jan. 30, 2001. Amended: Filed Dec. 20, 2010.*

**PUBLIC COST:** *This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

**PRIVATE COST:** *This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

**NOTICE TO SUBMIT COMMENTS:** *Anyone may file a statement in support of or in opposition to this proposed amendment with the County Employees' Retirement Fund, 2121 Schotthill Woods Drive, Jefferson City, MO 65101. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN**  
**Division 10—Health Care Plan**  
**Chapter 2—State Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-2.010 Definitions.** The Missouri Consolidated Health Care Plan is deleting sections (3), (19), (26), (33), (37), (44), (48), (51), (55), (56), (63), (65), (70), (72), (79), (93)–(95), (97), (100), (115), (125), and (129); amending sections (5), (9), (12), (17), (21), (25), (30), (34), (35), (37), (38), (42), (45), (47)–(49), (51), (52), (55), (68), (75)–(77), (79), (82), (88), (89), (91), (92), (94), (95), (97), (99), (101), (103)–(105), (108), (110), (112)–(114), (116),

(117), (119), (123), and (128); adding sections (2), (7), (8), (14), (15), (29), (31), (33), (40), (41), (44), (53), (56), (67), (69), (70), (73), (96), (125), (130), and (132)–(134); and renumbering as necessary.

**PURPOSE:** *This amendment changes policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan relative to state members.*

**PUBLISHER'S NOTE:** *The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.*

(2) Activities of daily living. Bathing, dressing, toileting, and associated personal hygiene; transferring (being moved in and out of a bed, chair, wheelchair, tub, or shower); mobility, eating (getting nourishment into the body by any means other than intravenous), and continence (voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

[(2)](3) Administrative appeal. A written request submitted by or on behalf of a member involving Missouri Consolidated Health Care Plan (MCHCP) administrative issues such as eligibility, effective dates of coverage, plan changes, etc.

[(3) Administrative guidelines. Instructive interpretation of the plan document developed for administration of the plan. The administrative guidelines may be changed upon approval of the executive director or his/her designee. Benefits provided shall be those in effect at the time services are rendered.]

(5) Allowable expense. Charges for services rendered or supplies furnished by a health plan that would qualify as covered expenses and for which the program pays in whole or in part, subject to any deductible[, and coinsurance[, or table of allowance included in the program] amounts.

(7) Applied behavior analysis. The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior.

(8) Assignment. When a doctor agrees to accept Medicare's fee as full payment.

[(7)](9) Benefit period. The three hundred sixty-five (365) days immediately *[following the first date of like services]* after the first date of services to treat a given condition.

[(8)](10) Benefits. Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator.

[(9)](11) Birthday rule. If both parents have medical coverage, the primary plan for dependent children is the plan of the parent whose birthday occurs first in the calendar year. If birthdays occur on the same day, the parent's coverage that has been in effect longest is primary.

[(10)](12) Board. The board of trustees of the Missouri Consolidated Health Care Plan (MCHCP).

**[(11)](13)** Calendar year. The period of time from January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All annual deductibles and benefit maximums accumulate during the calendar year.

**(14) Cancellation of coverage. The voluntary cancellation of medical, dental, or vision coverage per a subscriber's request.**

**(15) Case management. A coordinated set of activities conducted for individual patient management of serious or complicated health conditions.**

**[(12)](16)** Chiropractic services. The examination, diagnosis, adjustment, manipulation, and treatment of malpositioned articulations and structures of the body, directed toward restoring and maintaining the normal neuromuscular and musculoskeletal function and health.

**[(13)](17)** Claims administrator. An organization or group responsible for the processing of claims and associated services for *[the plan's self-insured benefit programs, including but not limited to the preferred provider organization (PPO) (also known as the copay plan) and health maintenance organization (HMO) type plans]* a health plan.

**[(14)](18)** Coinsurance. The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.

**[(15)](19)** Comprehensive major medical. A plan that provides for cost sharing to be applied to all covered expenses, such as deductible or coinsurance.

**[(16)](20)** Congenital defect. Existing or dating from birth. Acquired through development while in the uterus.

**[(17)](21)** Convenient care clinics (CCCs). Health care clinics located in retail stores, supermarkets, and pharmacies that treat routine family illnesses and provide preventive health care services. They are sometimes referred to as "retail-based clinics" or "walk-in medical clinics." *[CCCs are usually staffed by nurse practitioners or physician assistants. Some CCCs, however, are staffed by physicians.]*

**[(18)](22)** Coordination of benefits. Communication, adjustment, and reconciliation procedures between multiple benefit plans covering the same member for purposes of covering services and expenses relating to plan benefits.

**[(19) Copay plan. A set of benefits similar to a health maintenance organization option.]**

**[(20)](23)** Copayment. A set dollar amount that the covered individual must pay for specific services.

**[(21)](24)** Cosmetic surgery. A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than restore the anatomy and/or functions of the body which are lost or impaired due to illness or injury.

**[(22)](25)** Covered benefits and charges. *[A schedule of covered services and charges payable under the plan. The benefits covered under each type of plan are outlined in the applicable rule in this chapter.]* Covered benefits are a schedule of health care services payable under the plan. Covered charges are the cost for medical services eligible for consideration under the plan.

**[(23)](26)** Custodial care. Services and supplies furnished primarily to assist an individual to meet the activities of daily living/.

*Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services]* that can be provided by persons without the training of a health care provider or that do not entail and require the continuing attention of trained medical or paramedical personnel.

**[(24)](27)** Date of service. Date medical services are received or performed.

**[(25)](28)** Deductible. The amount of expense the member must pay before the plan begins to pay for covered services and supplies. This amount is not reimbursable by the plan.

**[(26) Dependent-only participation. Participation of certain survivors of subscribers. Dependent participation may be further defined to include the deceased subscriber's:**

- (A) Spouse only;
- (B) Child(ren) only; or
- (C) Spouse and child(ren).]

**(29) Dependent child. Any child under the age of twenty-six (26) that is a natural child, legally adopted or placed for adoption child, or a child with one (1) of the following legal relationships with the member, so long as such legal relationship remains in effect:**

- (A) Stepchild;
- (B) Foster child for whom the employee is responsible for health care;
- (C) Grandchild for whom the employee has legal guardianship or legal custody and is responsible for providing health care; and
- (D) Other child for whom the employee is the court-ordered legal guardian responsible for providing health care.

1. Except for a disabled child as described in 22 CSR 10-2.010(89), a dependent child is eligible from his/her eligibility date to the end of the month he/she attains age twenty-six (26) (see paragraph 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child beyond age twenty-six (26)).

**[(27)](30)** Dependents. The lawful spouse of the employee, the employee's *[unemancipated]* child(ren), and certain survivors of employees, as provided in the plan document and these rules, for whom *[application]* enrollment has been made and has been accepted for participation in the plan.

**(31) Diagnostic. Describes a procedure to determine whether a person has a particular illness.**

**[(28)](32)** Diagnostic charges. The Usual, Customary, and Reasonable (UCR) charges or the network discounted rate (NDR) for x-ray or laboratory examinations made or ordered by a physician in order to detect a medical condition.

**(33) Disease management. A program offered to non-Medicare members to help manage certain chronic diseases.**

**[(29)](34)** Disposable supplies. *[Medical s/Supplies* that do not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.

**[(30)](35)** Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:

- (A) Doctor of medicine;
- (B) Doctor of osteopathy;
- (C) Podiatrist;
- (D) Optometrist;
- (E) Chiropractor;
- (F) Psychiatrist;
- [(F)](G) Psychologist;

[(G)](H) Doctor of dental medicine, including dental surgery; [or]

**(I) Doctor of dentistry; or**

*[(H)](J)* Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

*[(31)](36)* Durable medical equipment (DME). Equipment able to withstand repeated use for the therapeutic treatment of an active illness or injury. Such equipment is not covered under the plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.

*[(32)](37)* Eligibility date. *[Refer to]* As described in 22 CSR 10-2.020. *[for effective date provisions.]*

*(A) Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of employment or reemployment.*

*(B) Employees transferred from a state department with coverage under another medical care plan into a state department covered by this plan and their eligible dependents who were covered by the other medical care plan are eligible for participation immediately.*

*(C) Employees who terminate all employment with the state (not simply move from one (1) agency to another) and are rehired as a new state employee before termination of participation, and their eligible dependents who were covered by the plan, will be eligible for participation immediately.*

*(D) Employees who terminate all employment with the state (not simply move from one (1) agency to another) and are rehired as a new state employee in the subsequent month, and their eligible dependents who were covered by the plan, will be eligible for participation retroactive to the date following termination of participation or at the employee's choice, on the first day of the month following the employee's date of rehire.]*

*[(33)]* Emancipated child(ren). A child(ren) who is:

- (A) Employed on a full-time basis;*
- (B) Eligible for group health benefits in his/her own behalf;*
- (C) Maintaining a residence separate from his/her parents or guardian, except for full-time students in an accredited school or institution of higher learning; or*
- (D) Married.]*

*[(34)](38)* Emergency medical condition. *[Any medical condition leading a prudent layperson to seek immediate medical attention. This normally means the sudden onset of a health condition that manifests itself by acute symptoms and severity (including severe pain). Examples of medical emergencies include, but are not limited to:]* A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

- (A) Conditions placing a person's health in significant jeopardy;*
- (B) Serious impairment to a bodily function;*
- (C) Serious dysfunction of any bodily organ or part;*
- (D) Inadequately controlled pain; or*
- (E) Situations when the health of a pregnant woman or her unborn child are threatened.*

*[(35)](39)* Emergency room. The section of a hospital equipped to furnish emergency care to prevent the death or serious impairment of the covered person.

**(40) Emergency Services.** With respect to an emergency medical condition—

**(A)** A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department to evaluate such emergency medical condition; and

**(B)** Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the patient. The term “to stabilize” means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility.

**(41) Employee.** A person employed by the state and present and future retirees from state employment who meet the eligibility requirements as prescribed by law.

*[(36)](42)* Employee and dependent participation. Participation of an employee and the employee's eligible dependents. Any individual eligible for participation as an employee is *[not]* eligible as a dependent up to the age of twenty-six (26), except as noted in 22 CSR 10-2.020(1)(A)3. *[Dependent participation may be further defined to include the participating employee's:]*

- (A) Spouse only;*
- (B) Child(ren) only; or*
- (C) Spouse and child(ren).]*

*[(37)]* Employees. Employees of the state and present and future retirees from state employment who meet the eligibility requirements as prescribed by state law.]

*[(38)](43)* Employer. The state department or agency that employs the eligible employee as defined above.

**(44) Essential benefits.** The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

- (A)** Ambulatory patient services—office visits, urgent care, outpatient diagnostic procedures, outpatient surgery, and outpatient hospice;
- (B)** Emergency services—ambulance services and emergency room services;
- (C)** Hospitalization—inpatient hospital benefits, inpatient surgery, transplants, and inpatient hospice;
- (D)** Maternity and newborn care—maternity coverage and newborn screenings;
- (E)** Mental health and substance abuse disorder services, including behavioral health treatment—inpatient and outpatient and mental health/chemical dependency office visits;
- (F)** Prescription drugs;
- (G)** Rehabilitative and habilitative services and devices—durable medical equipment; cardiac and pulmonary rehabilitation; outpatient physical, speech, and occupational therapy; and home health care/palliative services;
- (H)** Laboratory services—lab and x-ray;
- (I)** Preventive and wellness services and chronic disease management; and
- (J)** Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, immunizations, preventive services, and newborn screenings.

*[(39)](45)* Executive director. The chief executive officer of the Missouri Consolidated Health Care Plan (MCHCP) who shall have charge of the offices, records, and employees of the plan, subject to the direction of the board of trustees.



[(40)](46) Experimental/Investigational/Unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below is considered experimental/investigational/unproven and is not eligible for coverage under the plan. Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community. Experimental/investigational/unproven is defined as a treatment, procedure, device, or drug that the plan administrator determines, in the exercise of its discretion[:]-

(A) Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law;

(B) Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or

(C) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficiency as compared with the standard means of treatment or diagnosis.

[(41)](47) First eligible. The first thirty-one (31)-day period after a member's employment date in which the member and his/her dependents may enroll in an MCHCP plan. As a member acquires new dependents, his/her first *[eligible]* eligibility period is the first thirty-one (31) days from the date *[the dependent meets the eligibility requirements for coverage under the plan]* of the life event.

[(42)](48) Formulary. A list of drugs covered by the pharmacy *[program claims administrator]* benefit manager and as allowed by the plan administrator.

[(43)](49) Generic drug. *[The chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.]* There are two (2) types of generic drugs, a therapeutically equivalent generic and a chemically equivalent generic, as defined below.

(A) Therapeutically equivalent generic drugs are drugs with active ingredients that are similar at the clinical level.

(B) Chemically equivalent generic drugs are drugs with active ingredients that are identical at the molecular level. The brand-name drug lost its patent and the generic is available for the exact drug.

[(44)] Grievance. A written complaint submitted by or on behalf of a member regarding either:

(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or

(B) Claims payment, handling, or reimbursement for health care services.]

[(45)](50) Group health plan. A plan maintained by an employer or an employee organization to provide medical care or other health services, directly or indirectly, to employees, former employees, and their families, including but not limited to Medicare and Medicaid plans.

[(46)](51) Handbook. The summary plan document prepared for members explaining the terms, conditions, and all material aspects of the plan and benefits offered under the plan, a copy of which is incorporated by reference into this rule. The full text of material

incorporated by reference *[will be made]* is available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, 2010 State Member Handbook *([January 1, 2010] January 10, 2011)* or online at [www.mchcp.org](http://www.mchcp.org). It does not include any later amendments or additions.

[(47)](52) Health assessment (HA). A questionnaire about a member's health and lifestyle habits *[which qualifies the member]* required for participation in the *[Lifestyle Ladder program to earn the incentive premium]* wellness program.

(53) Health care benefit. Coverage under the plan to include medical, dental, vision, and pharmacy.

[(48)] Health maintenance organization (HMO). A plan that provides for a wide range of comprehensive health care services for a specified group at a fixed periodic prepayment.]

[(49)](54) Health savings account (HSA). A tax-advantaged savings account that may be used to pay current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA. HSA funds can be used to help pay the deductible, coinsurance, and any qualified medical expenses not covered by the health plan.

[(50)](55) High Deductible Health Plan (HDHP). A health plan with higher deductibles than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

[(51)] Home health agency. An agency certified by Medicare and the Missouri Department of Health and Senior Services, or any other state's licensing or certifying body, to provide health care services to persons in their homes.]

(56) Home health care. Skilled nursing services and other therapeutic services to persons in their homes provided by an agency certified by Medicare and licensed pursuant to state or local law.

[(52)](57) Hospice. A public agency, private organization, or a subdivision of either that primarily engages in providing care to terminally ill individuals, meets the conditions of participation for hospices, holds a valid Medicare provider agreement, and is licensed pursuant to state law.

[(53)](58) Hospice facility. A public or private organization, certified by Medicare and any other state's licensing or certifying body, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one (1) physician, one (1) registered nurse, one (1) social worker, one (1) volunteer, and a volunteer program. A hospice facility is not a facility or part thereof which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.

[(54)](59) Hospital.

(A) An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic, and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24)-hour-a-day nursing service by a registered nurse (RN) on duty or call.

(B) An institution not meeting all the requirements of [(54)](A) subsection (59)(A) above, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

(C) An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).

(D) A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.

(E) A residential alcoholism, chemical dependency, or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction.

(F) In no event shall the term hospital include a skilled nursing facility or any institution or part thereof which is used primarily as a skilled nursing facility, nursing home, rest home, or facility for the aged.

*[(55) Hospital copayment. Set dollar amount a subscriber must pay for each hospital admission.]*

*[(56) Hospital room charges. The hospital's most common charge for semi-private accommodations, or the most common charge for a private room if that is the only type of room available or if a private room has been recommended by a physician and approved by the claims administrator or the plan administrator.]*

*[(57)](60) Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered as any other illness.*

*[(58)](61) Incident. A definite and separate occurrence of a condition.*

*[(59)](62) Infertility. Any medical condition causing the inability or diminished ability to reproduce.*

*[(60)](63) Infertility services. Services including confinement, treatment, or other services related to the restoration of fertility or the promotion of conception.*

*[(61)](64) Injury. A condition that results independently of an illness and all other causes and is a result of an external force or accident.*

*[(62)](65) Inpatient. Confined to a registered bed. Patient in hospital, skilled nursing facility, hospice facility, or free-standing chemical dependency treatment center.*

*[(63) Legend. Any drug that requires a prescription from either a physician or a practitioner, under either federal or applicable state law, in order to be dispensed.]*

*[(64)](66) Life events. Events occurring in an individual's life to include: marriage, birth, adoption, or placement of children.*

**(67) Lifestyle Ladder. MCHCP's wellness program.**

*[(65) Lifetime. The period of time a member or the member's eligible dependents participate in the plan.]*

*[(66)](68) Lifetime maximum. The [maximum] amount payable by a medical plan during a covered member's life for specific non-essential benefits.*

**(69) MCHCPid. An individual MCHCP member identifier used for member verification and validation.**

**(70) myMCHCP. A secure MCHCP member website that includes coverage selection, level of coverage, an option to change**

**a mailing address, an option to add or change an email address, an option to request an MCHCPid card, and access to other pertinent websites.**

*[(67)](71) Medical benefits coverage. Services that are received from providers recognized by the plan and are covered benefits under the plan.*

*[(68)](72) Medically necessary. Treatments, procedures, services, or supplies that the plan administrator determines, in the exercise of its discretion:/—*

(A) Are expected to be of clear clinical benefit to the patient; and

(B) Are appropriate for the care and treatment of the injury or illness in question; and

(C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.

**(73) Medicare approved amount. The fee Medicare sets as reasonable for a covered medical service. This is the amount a provider is paid by the member and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or provider.**

*[(69)](74) Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.*

*[(70) Morbid obesity. Body Mass Index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions approved by the plan administrator based on clinical review.]*

*[(71)](75) Network provider. A physician, hospital, pharmacy, [etc.,] or other health provider that is contracted with the plan or its designee.*

*[(72) Non-embedded deductible. The family deductible that must be met before claim payments begin, applicable when two (2) or more family members are covered in the HDHP.]*

*[(73)](76) Non-formulary. A drug not contained on the pharmacy [program's formulary] benefit manager's list [but may be covered under the terms and conditions of the plan] of covered drugs.*

*[(74)](77) Non-network provider or non-participating provider. A[ny] physician, hospital, pharmacy, [etc.,] or other health provider that does not have a contract with the plan or its designee.*

*[(75)](78) Nurse. A registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule.*

*[(76)](79) Nursing home. An institution operated, pursuant to law, primarily for custodial care or for patients [convalescing] recovering from illness or injury, under the supervision of a physician or*

registered nurse and having twenty-four (24)-hour nursing care. Also, an institution meeting the preceding criteria which is established for the treatment of sick and injured persons through spiritual means and is operated under the authority of organizations *[which] that* are recognized under Medicare.

*[(77)](80)* Open enrollment period. A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year.

*[(78)](81)* Out-of-area. Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria.

*[(79)]* Out-of-network. *Providers that do not participate in the member's health or pharmacy plan.*

*[(80)](82)* Out-of-pocket maximum. *[The maximum amount the member must pay before the plan begins paying one hundred percent (100%) of covered charges for the remainder of the calendar year.] The annual limit on the amount a member must pay for covered services. Above this limit, the medical plan pays one hundred percent (100%) for covered services for the rest of the plan year.*

*[(81)](83)* Outpatient. Treatment either outside a hospital setting or at a hospital when room and board charges are not incurred.

*[(82)](84)* Outpatient observation stay. Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services are less than twenty-four (24) hours. Members may receive observation services in the emergency room, an observation unit, the intensive care unit, or a regular floor.

*[(83)](85)* Palliative services. Care provided by a team approach that improves the quality of life for patients and their families facing problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and *[impeccable]* assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

*[(84)](86)* Partial hospitalization. A distinct and organized intensive ambulatory treatment service, less than twenty-four (24)-hour daily care specifically designed for the diagnosis and active treatment of a mental/nervous disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.

(A) Partial hospitalization programs must provide diagnostic services; services of social workers; *[psychiatric]* nurses and staff trained to work with psychiatric patients; individual, group, and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions *[for therapeutic purposes]*.

(B) The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a physician.

*[(85)](87)* Participant. Any employee or dependent accepted for membership in the plan.

*[(86)](88)* Pharmacy benefit manager (PBM). *[Acts as a link between the parties involved in the delivery of prescription drugs to health plan members.]* The PBM designs, implements,

and manages the overall drug benefit of the plan and processes claims payments.

*[(87)](89)* Physically or mentally disabled. *[The inability of a person] A person's inability* to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition.

*[(88)](90)* Physician/Doctor. A licensed practitioner of the healing arts, acting within the scope of his/her practice, as licensed under section 334.021, RSMo.

*[(89)](91)* Plan. The program of health care benefits established by the **board of** trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

*[(90)](92)* Plan administrator. The **board of** trustees of the Missouri Consolidated Health Care Plan/. *As such, the board/, which* is the sole fiduciary of the plan/,/. **The board** has all discretionary authority to interpret its provisions and to control the operation and administration of the plan/,/ and whose decisions are final and binding on all parties.

*[(91)](93)* Plan document. The statement of the terms and conditions of the plan as promulgated by the plan administrator in this chapter.

*[(92)](94)* Plan year. *[Same as] The calendar year beginning January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All deductibles and benefit maximums accumulate during the calendar year.*

*[(93)]* Pre-admission testing. *X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission.]*

*[(94)]* Pre-certification. *Also known as pre-admission certification, pre-admission review, and pre-certification. The process of obtaining certification or authorization from the plan for routine hospital admissions and surgical or diagnostic procedures (inpatient or outpatient).]*

*[(95)]* Pre-existing condition. *A condition for which a member has incurred medical expenses or received treatment prior to the effective date of coverage.]*

*[(96)](95)* Preferred provider organization (PPO). An arrangement with providers whereby discounted rates are given to **plan** members *[of the plan who, in turn, are offered a financial incentive to use these providers]. Benefits are paid at a higher level when network providers are used.*

*[(97)]* Prevailing fee. *The fee charged by the majority of dentists.]*

**(96) Preventive service. A procedure intended for avoidance or early detection of an illness.**

*[(98)](97)* Primary care physician (PCP). A physician (usually an internist, family/general practitioner, or pediatrician) who has contracted with *[and been approved by]* a medical plan.

*[(99)](98)* Prior authorization. A cost control procedure that requires the service or medication to be approved in advance by the doctor and/or the plan. Without prior authorization, the plan may not pay for the test, drug, or service. Also known as pre-authorization or pre-notification.

*[(100)]* Prior plan. *The terms and conditions of a plan in effect for the period preceding coverage in the plan.]*

[(101)](99) Private duty nursing. *[Private duty nursing services, n/Nursing care on a full-time basis in the member's home[,] or home health aides.*

[(102)](100) Proof of eligibility. Documentation required by the plan to determine a dependent's qualification for health insurance coverage.

[(103)](101) Proof of **prior group** insurance. Evidence in written form from an insurance company that provides verification of coverage for a given period of time.

[(104)](102) Proof of prior group coverage. If a member or his/her dependents enroll in the plan due to loss of coverage, the member must provide proof of prior group coverage. This includes a letter from the previous insurance carrier or former employer which states all the following:

- (A) Date coverage was or will be terminated;
- (B) Reason for coverage termination; and
- (C) List of dependents covered.

[(105)](103) Prostheses. An artificial extension that replaces a missing part of the body/. *Prostheses are typically used to replace parts lost by injury (traumatic) or missing from birth (congenital)] or [to] supplements defective parts.*

[(106)](104) Protected health information (PHI). Any information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. This information also relates to the past, present, or future physical or mental health or condition of the individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual.

[(107)](105) Provider. *[Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.] A physician, hospital, medical agency, specialist, or other duly-licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-2.010(35). Other providers include but are not limited to:*

- (A) Audiologist (AUD or PhD);
- (B) Certified Addiction Counselor for Substance Abuse (CAC);
- (C) Certified Nurse Midwife (CNM)—when acting within the scope of their license in the state in which they practice and performing a service which would be payable under this plan when performed by a physician;
- (D) Certified Social Worker or Masters in Social Work (MSW);
- (E) Licensed Clinical Social Worker;
- (F) Licensed Professional Counselor (LPC);
- (G) Licensed Psychologist (LP);
- (H) Nurse Practitioner (NP);
- (I) Physicians Assistant (PA);
- (J) Qualified Occupational Therapist;
- (K) Qualified Physical Therapist;
- (L) Qualified Speech Therapist;
- (M) Registered Nurse Anesthetist (CRNA);
- (N) Registered Nurse Practitioner (ARNP); or
- (O) Therapist with a PhD or Master's Degree in Psychiatry or related field.

[(108)](106) Provider directory. A listing of network providers within a health plan.

[(109)](107) Prudent layperson. An individual possessing an average knowledge of health and medicine.

[(110)](108) Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or *[an enrollee] member* if the plan normally provides coverage for dependent children.

[(111)](109) Reconstructive surgery. A procedure performed to restore the anatomy and/or functions of the body that are lost or impaired due to an injury or illness.

[(112)](110) Refractions. A record of the patient's preference for the focusing of the eyes that *[can] may* then be used to purchase eyeglasses **or contact lenses**. It is the *[portion of the eye] part of the* exam that determines what prescription lens *[provides] gives* the patient *[with]* the best possible vision.

[(113)](111) Rehabilitation facility. A legally operating institution, or distinct part of an institution, that has a transfer agreement with one (1) or more hospitals and is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute hospital, and rehabilitative inpatient care and is duly licensed by the appropriate government agency to provide such services.

(A) It does not include institutions that provide only minimal care, custodial care, ambulatory or part-time care services, or an institution that primarily provides treatment of mental/nervous disorders, substance abuse, or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission for the Accreditation of Rehabilitation Facilities.

[(114)](112) Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-2.020[(5)](B)](7)(B) and is currently receiving a monthly retirement benefit from *[one (1) of the]* a retirement system/s listed in such rule.

[(115)] *Second opinion program. A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service.]*

[(116)](113) Skilled nursing care. *[Care which] Services that* must be performed by, or under the supervision of, licensed personnel and meets criteria as established by the claims administrator.

[(117)](114) Skilled nursing facility (SNF). *[An institution which meets fully each of the following requirements:*

(A) *It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board, and twenty-four (24)-hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;*

(B) *It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and*

(C) A skilled nursing facility shall be deemed to include institutions meeting the criteria in this rule which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97).] A public or private facility licensed and operated according to the law that provides—

(A) Permanent and full-time facilities for ten (10) or more resident patients;

(B) A registered nurse or physician on full-time duty in charge of patient care;

(C) At least one (1) registered nurse or licensed practical nurse on duty at all times;

(D) A daily medical record for each patient;

(E) Transfer arrangements with a hospital; and

(F) A utilization review plan.

The facility must be primarily engaged in providing continuous skilled nursing care for persons during the recovery stage of their illness or injury, and is not, other than by coincidence, a rest home for custodial care or for the aged.

[[118]](115) Sound natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

[[119]](116) Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

[[120]](117) Specialty medications. High cost drugs that are primarily self-injectible; *[but]* sometimes oral medications.

[[121]](118) State. Missouri.

[[122]](119) Step therapy. Designed to encourage use of therapeutically-equivalent, lower-cost alternatives before *[stepping up to]* using more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

[[123]](120) Subrogation. The substitution of one (1) “party” for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the participant and recover the money directly from the other insurer.

[[124]](121) Subscriber. The employee or member who elects coverage under the plan.

[[125)](122) Subscriber only participation. Participation of a subscriber without participation of the subscriber’s dependents, whether or not the subscriber has dependents.]

[[126]](122) Surgery. Any operative or invasive diagnostic procedure performed in the treatment of an injury or illness by an instrument or cutting procedure through any natural body opening or incision.

[[127]](123) Surgery center (ambulatory). A hospital-based, hospital-sponsored, or independently-owned facility that performs surgery.

[[128]](124) Survivor. A member who meets the requirements of subsection 22 CSR 10-2.020/(5)/(A)/(7)(A).

(125) Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

[[129)](125) Unemancipated child(ren). A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-five (25) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

(A) Stepchild(ren);

(B) Foster child(ren) for whom the employee is responsible for health care;

(C) Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care; and

(D) Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator.

1. Except for a disabled child(ren) as described in section (87) of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-five (25) (see paragraph 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child(ren) beyond age twenty-five (25)); and

(E) Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for providing coverage is also covered as a dependent under the plan.]

[[130]](126) Urgent care. Medically necessary services in order to prevent rapid and/or serious deterioration in a member’s health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician office but not severe enough to require treatment in a hospital emergency department.

[[131]](127) Urgent care centers. Medical facilities that provide extended or twenty-four (24)-hour service to treat minor conditions at a lower cost than emergency room treatment.

[[132]](128) Usual, Customary, and Reasonable charge.

(A) Usual. The fee a *[physician]* provider most frequently charges the majority of his/her patients for the same or similar services.

(B) Customary. The range of fees charged in a geographic area by *[physicians]* providers of comparable skills and qualifications for the same performance of similar service.

(C) Reasonable. The flexibility to take into account any unusual clinical circumstances involved in performing a particular service.

(D) A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the *[doctors]* providers for ninety percent (90%) of the procedures reported.

[[133]](129) Utilization review. Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities on a prospective, concurrent, or retrospective basis.

(130) Vendor. The current applicable third-party administrator of MCHCP benefits.

[[134]](131) Vested subscriber. A member who meets the requirements of subsection 22 CSR 10-2.020/(5)/(B)/(7)(B).

(132) Wellness participation year. Year in which members may participate in the wellness program per plan year: October 1–September 25.

**(133) Wellness program.** A voluntary program focusing on awareness, health education, and behavior change.

**(134) Wellness premium.** The monthly medical premium applied to members who successfully complete all requirements of the Lifestyle Ladder program.

*AUTHORITY:* section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the *Code of State Regulations*. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Amended: Filed Dec. 22, 2010.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-2.020 [Subscriber Agreement and] General Membership Provisions.** The Missouri Consolidated Health Care Plan is amending the rule title and purpose; amending sections (1)–(3) and (5)–(10); adding new sections (5), (6), and (11)–(13); and renumbering as necessary.

*PURPOSE:* This amendment changes the policy of the board of trustees in regard to the General Membership Provisions of the Missouri Consolidated Health Care Plan.

*PURPOSE:* This rule establishes the policy of the board of trustees in regard to the [Subscriber Agreement and] General Membership Provisions of the Missouri Consolidated Health Care Plan.

(1) [The participant's initial application, any subsequently accepted modifications to such application, the handbook, and the plan document as adopted by the board along with duly executed amendments shall comprise the subscriber agreement between the participant and the Missouri Consolidated Health Care Plan (MCHCP). Any other written materials interpreting the subscriber agreement for the benefit of members and administrators are not a part of the subscriber agreement.] The member handbook and plan document provides the terms and conditions for membership in the Missouri Consolidated Health Care Plan (MCHCP). The member warrants that the information s/he provides in the enrollment process, whether by online enrollment in the Statewide Employee Benefit Enrollment System (SEBES), Open Enrollment, written form, or in other such organized methods, are true and accurate representation of fact.

(A) By [applying for] enrolling in coverage under the MCHCP, a participant agrees that—

1. The employer may deduct the cost of the premium for the employee's plan from the employee's paychecks; and

[2. Individual and family deductibles, if appropriate, will be applied; and]

[3.]2. Any individual eligible as an employee shall not be covered as a dependent unless the employee is under the age of twenty-six (26) or is on an approved leave of absence.

(B) A new employee must enroll or waive coverage through SEBES at [www.sebes.mo.gov](http://www.sebes.mo.gov) within thirty-one (31) days of his/her hire date. A new employee's coverage begins on the first day of the month after enrollment. A new employee will receive a SEBES enrollment password by email if the employee's human resource/payroll representative enters a valid email address in SEBES. Otherwise, the SEBES password will be mailed to the new employee's home address.

(C) An employee who does not enroll or waive medical coverage within the first thirty-one (31) days will be automatically enrolled in the PPO 600 Plan effective the first day of the month following the end of his/her thirty-one (31)-day eligibility period. The automatic enrollment will apply only to the employee and not to any of his/her dependents.

(D) A dependent may only be covered by one (1) parent if his/her parents are married and are both covered under an MCHCP medical plan.

(E) A member cannot be covered as a subscriber and a dependent.

(F) A dependent may have dual coverage if his/her parents are divorced or have never married and are both covered under an MCHCP medical plan.

1. MCHCP will only pay a service once regardless if the claim for the dependent's service is filed under multiple subscribers' coverage. MCHCP will process the claim and apply applicable cost-sharing using coverage through the subscriber who files the claim first. The second claim for the same services will not be covered.

2. If a provider files a claim simultaneously under both subscribers, the claim of the subscriber with the birthday first in the calendar year will be processed and applicable cost-sharing will be determined.

3. If a dependent has coverage under two (2) subscribers, the dependent will have a separate deductible and coinsurance under each subscriber.

(2) The effective date of participation shall be determined, subject to the effective date provision in subsection (2)(C), as follows:

(A) Employee Participation.

1. If [application] enrollment by an employee is made on or before the date of eligibility, participation shall become effective on such date of eligibility;/.

2. If [application] enrollment by an employee is made within thirty-one (31) days after the date of eligibility, participation may become effective on the date of eligibility or the first day of the calendar month coinciding with or following the date the [application] enrollment is received[, except that participation shall be retroactive to the beginning of the month for employees rehired during the month following the month participation would have terminated; and].

3. Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of employment or re-employment.

4. Employees transferred from a state department with coverage under another medical care plan into a state department covered by this plan, and their eligible dependents who were covered by the other medical care plan, are eligible for participation

immediately.

5. Employees who terminate all employment with the state (not simply move from one (1) agency to another) and are rehired as a new state employee before termination of participation, and their eligible dependents who were covered by the plan, will be eligible for participation immediately.

6. Employees who terminate all employment with the state (not simply move from one (1) agency to another) and are rehired as a new state employee in the subsequent month, and their eligible dependents who were covered by the plan, will be eligible for participation retroactive to the date following termination of participation or, at the employee's choice, on the first day of the month following the employee's date of rehire. If the employee chooses the first day of the month following his/her date of rehire, he/she will be considered a new hire and can add dependents or change plans.

[3.77. Not limiting or excluding any of the other provisions, if [application] enrollment is not made within thirty-one (31) days of the employee's date of eligibility, they may apply for coverage only if one (1) of the following occurs:

A. Occurrence of a life event which includes marriage, birth, adoption, and placement of **adopted** children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event;

B. Loss of a spouse's employer-sponsored group coverage when the employee originally waived coverage through the plan. [Application] Enrollment must be made within sixty (60) days of the time—

(I) The employee no longer qualifies for coverage under spouse's plan;

(II) The spouse's employment terminates or he/she is no longer eligible for coverage under employer's plan;

(III) The spouse's employer-sponsored medical, dental, and/or vision plan terminates;

(IV) All employer contributions toward the spouse's plan cease; or

(V) The employee's Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or

C. Loss of eligibility for Medicaid, in which case [application] enrollment for coverage through the plan must be made within sixty (60) days of loss;

(B) Dependent Coverage. Dependent participation cannot precede the subscriber's participation except when coverage is added as a life event with birth of a child or adoption of a child at birth. The effective date for a [child] newborn is the date of birth. The subscriber and/or dependent's effective date is the first day of the calendar month coinciding with or following the date of the [application] enrollment. [Application] Enrollment for participants must be made in accordance with the following provisions. Effective dates for all dependent coverage is wholly dependent upon—

1. Proof of eligibility documentation is required for all dependents. The plan reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by the plan administrator, coverage for the applicable dependent will either be terminated or will never take effect.

A. For the addition of dependents: Required documentation should accompany the [application] enrollment for coverage, except when adding a newborn. Failure to provide acceptable documentation with the [application] enrollment will result in the dependent not having coverage until such proof is received, subject to the following:

(I) If proof of eligibility is not received with the [application] enrollment, such proof will be requested by letter sent to the subscriber. Documentation shall be received no later than thirty (30) days from the date of the letter requesting such proof. Failure to provide the required documentation in a timely manner will result in the

dependent being ineligible for coverage until the next open enrollment period unless a life event occurs; and

(II) Coverage is provided for a newborn of a member from the moment of birth. A change form, available by accessing state member information at [www.mchcp.org](http://www.mchcp.org), and proof of eligibility must be submitted prior to the birth or within the applicable time frame required by law. [However, c]Coverage will not continue past the first thirty-one (31) days unless required documentation is received;

2. Documentation is also required when a subscriber attempts to terminate a dependent's coverage in the case of divorce or death;

3. Acceptable forms of proof of eligibility are included in the following chart:

Circumstance	Documentation
Birth of dependent(s)	<ul style="list-style-type: none"> <li>• Government-issued /B/birth certificate;/ or other government-issued or legally-certified proof of eligibility</li> <li>• Hospital certificate/</li> </ul>
Addition of step-child(ren)	<ul style="list-style-type: none"> <li>• Marriage license to biological parent of child(ren); and</li> <li>• Birth [or Hospital] certificate for child(ren) that names the subscriber's spouse as a parent</li> </ul>
Addition of foster child(ren)	<ul style="list-style-type: none"> <li>• Placement papers in subscriber's care</li> </ul>
Adoption of dependent(s)	<ul style="list-style-type: none"> <li>• Adoption papers; [or]</li> <li>• Placement papers; or</li> <li>• Filed petition for adoption</li> </ul>
Legal guardianship of dependent(s)	<ul style="list-style-type: none"> <li>• Court-documented guardianship papers (Power of Attorney is not acceptable)</li> </ul>
Newborn of covered dependent	<ul style="list-style-type: none"> <li>• Government-issued /B/birth certificate for newborn listing covered dependent as parent with baby's name and birth date</li> </ul>
Marriage	<ul style="list-style-type: none"> <li>• Marriage license;</li> <li>• Marriage certificate; or</li> <li>• Newspaper notice of the wedding</li> </ul>
Divorce	<ul style="list-style-type: none"> <li>• Final divorce decree; or</li> <li>• Notarized letter from spouse stating he/she is agreeable to termination of coverage pending divorce</li> </ul>
Death	<ul style="list-style-type: none"> <li>• Death certificate</li> </ul>

4. For family coverage, once a subscriber is participating with respect to dependents, newly acquired dependents are automatically covered on their effective dates as long as the plan administrator is notified within thirty-one (31) days of the person becoming a dependent. First eligible dependents must be added within thirty-one (31) days of such qualifying event. The employee is required to notify the plan administrator on the appropriate form of the dependent's name, date of birth, eligibility date, and Social Security number[, if available]. Members who are eligible for Medicare benefits under Part A, B, or D must notify the plan administrator of their eligibility and provide a copy of the member's Social Security and Medicare cards within thirty-one (31) days of eligibility of Medicare. Claims will not be processed until the required information is provided;

5. If an employee makes concurrent [application] enrollment



for dependent participation on or before the date of eligibility or within thirty-one (31) days thereafter, participation for dependent will become effective on the date the employee's participation becomes effective;

6. When an employee participating in the plan first becomes eligible with respect to a dependent child(ren), coverage may become effective on the eligibility date or the first day of the month coinciding with or following the date of eligibility if *[application]* **enrollment** is made within thirty-one (31) days of the date of eligibility and provided any required contribution for the period is made; and

7. Survivors, retirees, vested subscribers, and long-term disability subscribers may only add dependents to their coverage when the dependent is first eligible for coverage, *[except]* **add dependents under the age of twenty-six (26) at open enrollment for the 2011 plan year only, add a newborn of a covered dependent, or** when a dependent's employer-sponsored coverage ends due to one (1) of the following:

A. Termination of employment;

B. Retirement; *[and]* **or**

C. Termination of group coverage by the employer.

Coverage must have been in place for twelve (12) months immediately prior to the loss, and coverage must be requested within sixty (60) days from the termination date of the previous coverage;

(C) **Effective Date Provision.** The effective date of coverage is the first of the month coinciding with or following the eligibility date and the date the form is received by the plan. The effective date of coverage cannot be prior to the date of receipt of the enrollment form by the plan. **The effective date is determined by the date the enrollment is received by the plan administrator.** The effective date for dependent coverage is wholly dependent upon the appropriate proof of eligibility documentation being timely received by the plan (see paragraph (2)(B)1.);

(D) *[Application]* **Enrollment** for dependent coverage may be made within sixty (60) days when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's—

1. Employer-sponsored medical, dental, or vision plan terminates or coverage by the employer is no longer offered;

2. The employer contributions toward the premiums cease;

3. COBRA coverage ceases; or

4. A dependent no longer qualifies due to age;

(E) *[Application]* **Enrollment** may be made for dependent coverage within sixty (60) days *[of the event—]* **for a dependent who no longer qualifies for Medicaid;**

*[1. A Qualified Medical Child Support Order is received;*  
*or*

*2. A dependent no longer qualifies for Medicaid; or]*

(F) *[Application]* **may be made for dependent coverage within thirty-one (31) days of an emancipated dependent regaining dependent status.] A Qualified Medical Child Support Order is effective the first of the month coinciding with or the month following the date the form is received by the plan.**

(3) Termination of participation shall occur on the last day of the calendar month coinciding with or following the happening of any of the following events, whichever shall occur first:

(A) Written or phone request by the employee;

(B) Failure to make any required contribution toward the cost of coverage;

(C) Entry into the armed forces of any country. With respect to an employee, membership in the National Guard or Reserves with or without two (2) consecutive full weeks of active training each year shall not be considered as entry into the armed forces; *[or]*

(D) Termination of Eligibility for Participation.

1. With respect to employees, termination of participation shall occur upon termination of employment in a position covered by the MCHCP, except as **expressly specified** *[in sections (4) and (5)]* **otherwise in this rule.**

2. With respect to dependents, termination of participation shall

occur upon ceasing to be a dependent as defined in this *[rule]* **chapter** or upon failure to provide the plan with acceptable proof of eligibility with the following exception: *[unemancipated]* mentally and/or physically handicapped children will continue to be eligible beyond age *[twenty-five (25)]* **twenty-six (26)** during the continuance of a permanent disability provided **the following** documentation *[satisfactory to the plan administrator]* is *[furnished by a physician]* **submitted to the plan** prior to the dependent's twenty-*[fifth]***sixth** birthday*[, and as requested at the discretion of the plan administrator.]*:

A. The SSI Notice of Award from the Social Security Administration (SSA) verifying the dependent is entitled to and receiving disability benefits as of a specific date;

B. A letter from the dependent's physician describing the disability and verifying that the disability predates the SSA determination; and

C. A current benefit verification letter from the SSA confirming the dependent is still considered disabled by SSA.

3. Termination of employee's participation shall terminate the participation of dependents, except as specified in section *[(5)]***(7)**.

4. **Subscriber shall notify MCHCP when any of subscriber's dependents cease to be a dependent as defined in this chapter;**

(E) **Termination due to fraud or intentional misrepresentation;**  
**or**

(F) **A retroactive rescission will apply only to non-payment of a premium, fraud, or intentional misrepresentation.**

(5) **Terminating medical coverage is not an allowable reason to cancel dental and/or vision coverage during the year. A subscriber may only cancel dental and/or vision coverage during the year for themselves or their dependents for one (1) of the following reasons:**

(A) **Termination of employment;**

(B) **Termination of COBRA coverage;**

(C) **Retirement;**

(D) **Death;**

(E) **Leave of absence; or**

(F) **Dependent age of twenty-six (26).**

(6) **Voluntary Cancellation of Coverage.** A subscriber may retroactively cancel coverage for one (1) of the following reasons:

(A) **Cancellation of coverage on his/her spouse on the last day of the month in which a divorce is final. A copy of the divorce decree must accompany the change request; or**

(B) **Cancellation of coverage effective the last day of the prior month if the subscriber notifies MCHCP on the first calendar day of the current month.**

*[(5)]***(7)** Continuation of Coverage.

(A) Dependents. Termination of an active employee's participation by reason of death shall not terminate participation with respect to the surviving spouse and/or dependent children if the active employee was vested and eligible for a future retirement benefit and eligible dependents meet one (1) of the following conditions:

1. They have had coverage through MCHCP since the effective date of the last open enrollment period;

2. They have had other health insurance for the six (6) months immediately prior to the employee's death—proof of insurance is required; or

3. They have had coverage through MCHCP since they were first eligible.

(B) **Employee Eligible for Retirement Benefits.** Any employee who, at the time of termination of employment, met the following—

1. Eligibility criteria:

A. Coverage through MCHCP since the effective date of the last open enrollment period;

B. Other health insurance for the six (6) months immediately prior to the termination of state employment—proof of insurance is



required; or

C. Coverage since first eligible;

2. Immediately eligible to receive a monthly retirement benefit from the Missouri State Employees' Retirement System, Public School Retirement System, the retirement system of a participating public entity, or the Highway Retirement System may elect to continue to participate in the plan by paying the cost of plan benefits as determined by the plan administrator. An employee must apply for continued coverage within thirty-one (31) days of the first day of the month following the date of retirement. An employee, continuing coverage under this provision, may also continue coverage for eligible dependents.

A. If a member participates in the MCHCP as a vested member, his/her dependents may also participate if they meet one (1) of the following criteria:

(I) They have had coverage through MCHCP since the effective date of the last open enrollment period;

(II) They have had other health insurance for the six (6) months immediately prior to state employment termination—proof of insurance is required; or

(III) They have had coverage since they were first eligible;

3. In the case of the death of a retiree who was maintaining dependent coverage under this provision, the dependent of the deceased retiree may continue his/her participation under the plan. However, retirees, survivors, vested subscribers, and long-term disability subscribers and their dependents are not later eligible if they discontinue their coverage at some future time, except as noted in **[(5)/(B)4.] paragraph (7)(B)4.; and**

4. A vested or retired member may elect to suspend their coverage upon entry into the armed forces of any country by submitting a copy of their activation papers within thirty-one (31) days of their activation date. Coverage will be suspended the first of the month following the month of activation. Coverage may be reinstated at the same level upon discharge by submitting a copy of their separation papers and a completed enrollment form within thirty-one (31) days of their separation date. Coverage will be reinstated as of the first of the month following the month of separation.

(C) Coverage at Termination. A former employee may participate in the plan if s/he terminates employment before retirement provided s/he is a vested employee. This means s/he will be eligible for a benefit from the Missouri State Employees' Retirement System, the Public School Retirement System, the retirement system of a participating public entity, or the Missouri Department of Transportation and Highway Patrol Employees' Retirement System when s/he reaches retirement age. Coverage may also be continued by a member of the general assembly, a state official holding a statewide elective office, or an employee employed by an elected state official or member of the general assembly whose employment is terminated because the state official or member of the general assembly ceases to hold elective office. The election to participate must be made within thirty-one (31) days from the last day of the month in which employment terminated. The member must pay the full cost of coverage. However, s/he will not later be eligible if s/he discontinues coverage at some future time.

(D) Leave of Absence. An employee on approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify the plan administrator of the leave of absence and any extension of the leave of absence by submitting the required form. Any employee on an approved leave of absence who was a member of **[the Missouri Consolidated Health Care Plan] MCHCP** when the approved leave began, but who subsequently terminated participation in **[the Missouri Consolidated Health Care Plan] MCHCP** while on leave, may recommence his/her coverage in the plan at the same level (employee only or employee and dependents) upon returning to employment directly from the leave. However, eligibility is terminated for those members receiving a military leave of absence, as specified in subsection (3)(C). Coverage may be rein-

stated upon return from military leave. However, the former member must complete an enrollment form. Coverage under this provision is effective on the first of the month coinciding with or following the employee's return to work. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date and timely requests reinstatement of coverage.

(E) Layoff. An employee on layoff status may elect to retain eligibility to participate in the plan by paying the required contribution for a maximum of twenty-four (24) months with recertification of status at least every twelve (12) months by the employing department. Eligibility will terminate if the employee becomes eligible for health benefits as an employee of another employer. If participation terminates and the employee is recalled to service, eligibility will be as a new employee.

(F) Workers' Compensation. Any person who is receiving, or is entitled to receive, Workers' Compensation benefits as a result of an injury or accident sustained in employment and who was a member of the plan at the time of becoming disabled may continue his/her coverage in the plan at the same level of participation (subscriber only or subscriber and dependents) by paying the required contributions, if the disability occurred in the employment through which the employee qualifies for membership in the plan. Any person receiving, or entitled to receive, Workers' Compensation benefits who was a member of the plan at the time of becoming disabled as a result of an injury or accident sustained in employment through which the person qualified for membership in the plan, but who subsequently terminated participation in the plan, may recommence his/her coverage in the plan at the same level (subscriber only or subscriber and dependents) upon returning to employment.

(G) Reinstatement After Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action available as a recourse through his/her employer, s/he will be allowed to reinstate his/her medical benefit retroactively to the date of dismissal. If the employee is reinstated with back pay, s/he will be responsible for paying any contribution normally made for either his/her coverage or his/her covered dependents. If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making any required contribution toward the cost of his/her medical benefits. If the employee does not purchase coverage for the period between termination and reinstatement, s/he may regain the same level of coverage s/he had prior to termination. **If the employee does not continue coverage, s/he will be considered a new hire and may enroll in the plan of his/her choice.**

**[(6)/(8) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).**

(A) In accordance with **[the] COBRA**, eligible employees and their dependents may continue their medical coverage after the employee's termination date.

1. Employees terminating for reasons other than gross misconduct or receiving a reduction in the number of hours of employment may continue coverage for themselves and their covered dependents for eighteen (18) months at their own expense.

**2. A spouse and dependents may continue coverage for up to thirty-six (36) months at their expense if the covered employee enrolls in Medicare and notifies the plan administrator within sixty (60) days of his/her Medicare entitlement.**

**[2.]3.** A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

**[3.]4.** A divorced spouse and dependents may continue coverage at his/her own expense for up to thirty-six (36) months if the plan administrator is notified within sixty (60) days from the date coverage would terminate.

**[4. Dependent spouse and/or child(ren) may continue coverage up to thirty-six (36) months if the covered employee retires and the dependent spouse/child(ren) has not been**

*covered by the plan for two (2) years.]*

5. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense if the plan administrator is notified within sixty (60) days of the loss of the dependent's eligibility.

6. Employees who are disabled at termination or become disabled during the first sixty (60) days of coverage may continue coverage for up to twenty-nine (29) months.

7. An employee who is on military leave is eligible for continued coverage for medical and dental care for the lesser of: a) twenty-four (24) months beginning on the date the leave begins; or b) the day after the date the employee fails to apply for or return to their position of employment following leave.

[7.]/8. Premiums for continued coverage will be one hundred two percent (102%) of the health plan rate, one hundred fifty percent (150%) if disabled. Once coverage is terminated under the COBRA provision, it cannot be reinstated.

[8.]/9. All operations under the COBRA provision will be applied in accordance with federal regulations.

[[7]](9) Missouri State Law COBRA Wrap-Around Provisions—Missouri law provides that if a member loses group health insurance coverage because of a divorce, legal separation, or the death of a spouse, the member may continue coverage until age sixty-five (65) if: a) The member continues and maintains coverage under the thirty-six (36)-month provision of COBRA; and b) The member is at least fifty-five (55) years old when COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay all of the [application] premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium. The above Cancellation of Continuation Coverage also applies to COBRA wrap-around continuation.

[[8]](10) If any retired participants or long-term disability recipients, or their [eligible] dependents, [or surviving dependents] eligible for coverage elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage. If surviving dependents do not elect to continue their coverage within thirty-one (31) days of the first day of the month following the date of death, they may not later elect to be covered.

(11) Retirees and/or dependents may continue dental and/or vision coverage into retirement without medical coverage. At retirement, employees may add themselves and/or their dependents with proof of six (6) months of dental and/or vision coverage immediately prior to their employment termination date.

(12) Medicare.

(A) If a participant eligible for Medicare who is not eligible for this plan as the primary plan is not covered by Medicare, an estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement was for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims.

(B) If a participant eligible for Medicare Part D enrolls in a Medicare Part D plan in addition to coverage under this plan, such participant's benefit may be adjusted in order for the plan to avoid liability for filing a false claim under the subsidy reimbursement portion of Medicare Part D.

(13) Communications to Members.

(A) It is the member's responsibility to ensure that the plan administrator has current contact information for the member

and any dependent(s).

(B) A member must notify the plan administrator of a change in his/her mailing or email address as soon as possible, but no later than thirty (30) days of the change.

(C) It is the responsibility of all active employees and any members who elect to receive plan communication through email to ensure plan emails are not blocked as spam or junk mail by the member or by the member's service provider.

(D) Failure to update a mailing or email address may result in undeliverable mail/email of important informational material. All members will be held responsible for the content of communications mailed/emailed from the plan to members provided such communication is sent by the plan to the most recent contact information on file with the plan at the time of the mailing, and members who fail to receive a communication as a result of failing to update his/her mailing/email address may incur additional liability or miss member opportunities relating to their covered benefits.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Amended: Filed Dec. 22, 2010.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions \$384,770,124 in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities \$118,646,208 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title:**  
**Division Title:**  
**Chapter Title:**

<b>Rule Number and Name:</b>	<b>22 CSR 10-2.020 Subscriber Agreement and General Membership Provisions</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan</b>	<b>\$384,770,124</b>

**III. WORKSHEET**

Estimated cost is the annual cost of the MCHCP providing health care plans to all state employees and eligible retirees and dependents for calendar year 2011.

**IV. ASSUMPTIONS**

- Total enrollment as of November 17, 2010 (data used the CY2011 projection);
- Calendar year 2011 membership remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary.
- Actual costs will vary based upon actual utilization of services.

# **FISCAL NOTE PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.020 Subscriber Agreement and General Membership Provisions</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

## **II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>99,648 individuals enrolled in MCHCP plans for CY 2011</b>	<b>Individuals enrolled in MCHCP plans for CY 2011</b>	<b>\$118,646,208</b>

## **III. WORKSHEET**

Estimated cost is the annual cost for all MCHCP subscribers' premium costs for calendar year 2011.

## **IV. ASSUMPTIONS**

- Total enrollment as of November 17, 2010 (data used the CY2011 projection);
- Calendar year 2011 membership remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary, and insured premiums developed by Mercy Health Plans;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-2.045 Plan Utilization Review Policy.** The Missouri Consolidated Health Care Plan is amending section (1).

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan medical plans.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program *[consists of four (4) parts, as described in the following]* has the following components:

(A) *[Precertification—The medical necessity of a non-emergency hospital admission, specified procedures as documented in the claims administrator's guidelines, and/or skilled nursing services provided on an inpatient basis must be prior authorized by the appropriate claims administrator. For emergency hospital admissions, the claims administrator must be notified within forty-eight (48) hours of the admission. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;]* Prior authorization of services—The claims administrator must authorize some services in advance. Without prior authorization, any claim that requires prior authorization will not be covered. Participants who have another primary carrier, including Medicare, are not subject to this provision. Prior authorization does not verify eligibility or payment. Prior authorizations based on a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition will not be covered.

1. The following medical services are subject to prior authorization:

- A. Ambulance services for non-emergency use whether air or ground;
- B. Applied behavioral analysis for autism;
- C. Cardiac and pulmonary rehabilitation after thirty-six (36) visits within a twelve (12)-week period;
- D. Chiropractic services after twenty-six (26) visits annually;
- E. Cochlear implant device;
- F. Dental care to reduce trauma and restorative services when the result of accidental injury;
- G. Durable medical equipment (DME) over one thousand five hundred dollars (\$1,500) or DME rentals over five hundred dollars (\$500) per month;
- H. Genetic testing or counseling;
- I. Home health care and palliative services;
- J. Hospice care;
- K. Hospital inpatient services except for observation stays;
- L. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;
- M. Nutritional counseling after three (3) sessions annually;
- N. Orthotics over one thousand dollars (\$1,000);
- O. Oxygen provided on an outpatient basis;
- P. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per incident;
- Q. Prostheses over one thousand dollars (\$1,000);
- R. Skilled nursing facility;
- S. Surgery (outpatient)—The following outpatient surgical

procedures: potential cosmetic surgery, sleep apnea surgery, implantable stimulators, surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams; surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth; reduction of fractures and dislocations of the jaw; excision of exostosis of jaws and hard palate; external incisions and drainage of cellulitis; incision of accessory sinuses, salivary glands, or ducts; or frenectomy); and

T. Transplants including requests related to covered travel and lodging.

2. The following pharmacy services are subject to prior authorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications. Drugs that treat chronic, complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis. The specialty medication requires frequent dosage adjustments, clinical monitoring, and special handling and are often unavailable at retail pharmacies. The specialty medication must be filled through the claims administrator's home delivery pharmacy provider;

C. Medications that may be prescribed for several conditions including some where treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. The cost of the medication exceeds nine thousand nine hundred ninety-nine dollars and ninety-nine cents (\$9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents (\$1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents (\$149.99) for compound medications.

3. Prior authorization time frames.

A. A benefit determination for non-urgent prior authorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen (15)-calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least forty-five (45) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent prior authorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

(B) Concurrent Review—The claims administrator will *[continue to]* monitor the medical necessity of the inpatient admission *[and approve]* to certify the necessity of the continued stay in the hospital. *[Retirees and other participants for whom Medicare is the primary payor]* Participants who have another primary carrier, including Medicare, are not subject to this provision; and

*[(C) Large Case Management—Members who require long-term acute care may be offered the option of receiving the care, if appropriate, in a more cost-effective setting such as a skilled nursing facility or their own home. In some cases,*

this may require coverage for benefits that normally are not covered under the plan. These benefits may be provided through the approval of the claims administrator;

(D) *Hospital Bill Audits*—Certain hospital bills will be subject to review to verify that the services billed were actually provided and/or the associated billed amounts are accurate and appropriate; and

(E) *Penalties*—Members not complying with subsections (1)(A) and (B) of this rule may be subject to a financial penalty in connection with their covered benefits.]

(C) *Retrospective Review*—Reviews conducted after services have been provided to a patient. The retrospective review includes an evaluation of reimbursement levels, accuracy and adequacy of documentation or coding, or settling of payment.

*AUTHORITY:* section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the *Code of State Regulations*. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Amended: Filed Dec. 22, 2010.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED RESCISSION**

**22 CSR 10-2.050 Copay Plan Benefit Provisions and Covered Charges.** This rule established the policy of the board of trustees in regard to the Copay Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

*PURPOSE:* This rule is being rescinded because it is no longer needed.

*AUTHORITY:* section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the *Code of State Regulations*. Emergency rescission filed Dec. 20, 2010, effective Jan. 1, 2011, expires June 29, 2011. Rescinded: Filed Dec. 20, 2010.

*PUBLIC COST:* This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1)–(3).

*PURPOSE:* This amendment changes the policy of the board of trustees in regard to the PPO 300 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

(1) *Deductible amount*—Network: per individual each calendar year, three hundred dollars (\$300); family limit each calendar year, six hundred dollars (\$600). Non-network: per individual each calendar year, six hundred dollars (\$600); family limit each calendar year, one thousand two hundred dollars (\$1,200).

(A) *Network and non-network deductibles are separate.* Expenses cannot be shared or transferred between network and non-network benefits.

(B) *The family deductible is an aggregate of applicable charges received by all covered members of the plan.* Any combination of covered family member deductibles may be used to meet the family deductible. Applicable charges received by one (1) family member may only meet the individual deductible amount.

(C) *Married, active employees who are Missouri Consolidated Health Care Plan (MCHCP) subscribers need to meet only one (1) family deductible and out-of-pocket maximum.* Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all medical information of the family unit. Failure to report an active employee spouse when newly hired and during open enrollment will result in a separate deductible and coinsurance for both active employees.

(D) *During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance.* The newborn will not be subject to a separate deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital.

(2) *Coinsurance*—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(D) *Claims [may also] shall be paid at ninety percent (90%) if the subscriber requires covered services that are not available through a network provider within [fifty (50)] one hundred (100) miles of his/her home.* The participant must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is [not permanent] for three (3) months. After three (3) months, the participant must contact the claims administrator to reassess network availability.

(E) *Preventive care—network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible.*

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; *[percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits;]* **the amount the member pays due to noncompliance;** and charges above the maximum allowable amount for transplants performed by a non-network provider.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Amended: Filed Dec. 22, 2010.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions \$175,899,119 in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities \$59,252,605 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 2**

<b>Rule Number and Name:</b>	<b>22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan</b>	<b>\$ 175,899,119</b>

**III. WORKSHEET**

Estimated cost is the annual cost of the MCHCP providing the PPO 300 Plan to all state employees and eligible retirees and dependents who enrolled for coverage under this plan for calendar year 2011.

**IV. ASSUMPTIONS**

- Total enrollment under the PPO 300 Plan as of November 17, 2010 (data used the CY2011 projection);
- Calendar year 2011 membership in the PPO 300 Plan remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Actual costs will vary based upon actual utilization of services.



**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.051 PPO 300 Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>55,638 individuals enrolled in the MCHCP PPO 300 Plan for CY 2011</b>	<b>Individuals enrolled in the MCHCP PPO 300 Plan for CY 2011</b>	<b>\$59,252,605</b>

**III. WORKSHEET**

Estimated cost is the annual cost for all MCHCP subscribers' premium costs for coverage under the PPO 300 Plan for calendar year 2011. In addition, members will pay the following deductible and coinsurance amounts based upon their individual utilization of covered benefits under the PPO 300 Plan:

- \$300 individual network deductible
- \$600 family network deductible
- \$600 individual non-network deductible
- \$1,200 family non-network deductible
- 10 percent network coinsurance after deductible
- 30 percent non-network coinsurance after deductible
- \$1,200 individual network out-of-pocket maximum
- \$2,400 family network out-of-pocket maximum
- \$2,400 individual non-network out-of-pocket maximum
- \$4,800 family non-network out-of-pocket maximum

**IV. ASSUMPTIONS**

- Total enrollment in the PPO 300 Plan as of November 17, 2010 (data used for the CY2011 projection);
- Calendar year 2011 membership in the PPO 300 Plan remains relatively stable;

- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary, and insured premiums developed by Mercy Health Plans;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED RULE**

**22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 600 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.*

(1) Deductible amount—Network: per individual each calendar year, six hundred dollars (\$600); family limit each calendar year, one thousand two hundred dollars (\$1,200). Non-network: per individual each calendar year, one thousand two hundred dollars (\$1,200); family limit each calendar year, two thousand four hundred dollars (\$2,400).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) The family deductible is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member deductibles may be used to meet the family deductible. Applicable charges received by one (1) family member may only meet the individual deductible amount.

(C) Married, active employees who are Missouri Consolidated Health Care Plan (MCHCP) subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all medical information of the family unit. Failure to report an active employee spouse when newly hired and during open enrollment will result in a separate deductible and coinsurance for both active employees.

(D) During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance. The newborn will not be subject to a separate deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if he/she is transferred to another hospital.

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims—are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims shall be paid at ninety percent (90%) if the subscriber requires covered services that are not available through a network provider within one hundred (100) miles of his/her home. The participant must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is for three (3) months. After three (3) months, the participant must contact the claims administrator to reassess network availability.

(E) Preventive care—network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network out-of-pocket maximum for individual—one thousand five hundred dollars (\$1,500).

(B) Network out-of-pocket maximum for family—three thousand dollars (\$3,000).

(C) Non-network out-of-pocket maximum for individual—three thousand dollars (\$3,000).

(D) Non-network out-of-pocket maximum for family—six thousand dollars (\$6,000).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(4) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Original rule filed Dec. 22, 2010.*

*PUBLIC COST: This proposed rule will cost state agencies or political subdivisions \$140,810,113 in the aggregate.*

*PRIVATE COST: This proposed rule will cost private entities \$38,168,891 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 2**

<b>Rule Number and Name:</b>	<b>22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan</b>	<b>\$ 140,810,113</b>

**III. WORKSHEET**

Estimated cost is the annual cost of the MCHCP providing the PPO 600 Plan to all state employees and eligible retirees and dependents who enrolled for coverage under this plan for calendar year 2011.

**IV. ASSUMPTIONS**

- Total enrollment under the PPO 600 Plan as of November 17, 2010 (data used the CY2011 projection);
- Calendar year 2011 membership in the PPO 600 Plan remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Actual costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>42,933 individuals enrolled in the MCHCP PPO 600 Plan for CY 2011</b>	<b>Individuals enrolled in the MCHCP PPO 600 Plan for CY 2011</b>	<b>\$38,168,891</b>

**III. WORKSHEET**

Estimated cost is the annual cost for all MCHCP subscribers' premium costs for coverage under the PPO 600 Plan for calendar year 2011. In addition, members will pay the following deductible and coinsurance amounts based upon their individual utilization of covered benefits under the PPO 600 Plan:

- \$600 individual network deductible
- \$1,200 family network deductible
- \$1,200 individual non-network deductible
- \$2,400 family non-network deductible
- 10 percent network coinsurance after deductible
- 30 percent non-network coinsurance after deductible
- \$1,500 individual network out-of-pocket maximum
- \$3,000 family network out-of-pocket maximum
- \$3,000 individual non-network out-of-pocket maximum
- \$6,000 family non-network out-of-pocket maximum

**IV. ASSUMPTIONS**

- Total enrollment in the PPO 600 Plan as of November 17, 2010 (data used for the CY 2011 projection);
- Calendar year 2011 membership in the PPO 600 Plan remains relatively stable;

- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary, and insured premiums developed by Mercy Health Plans;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1)–(3) and (5) and adding new sections (6) and (7).

*PURPOSE:* This amendment changes the policy of the board of trustees in regard to the High Deductible Health Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

(1) Deductible amount—Network: per individual each calendar year, one thousand two hundred dollars (\$1,200); family limit each calendar year, two thousand four hundred dollars (\$2,400). Non-network: per individual each calendar year, two thousand four hundred dollars (\$2,400); family limit each calendar year, four thousand eight hundred dollars (\$4,800).

(A) The family deductible must be met before claim payments begin, applicable when two (2) or more family members are covered.

(B) If both a husband and wife are state employees covered by Missouri Consolidated Health Care Plan (MCHCP) and they both enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), they must each have a separate HSA. The maximum contribution MCHCP will make for the family is one thousand four hundred dollars (\$1,400) regardless of the number of HSAs or the number of children covered under the HDHP for either parent. MCHCP will consider married state employees as one (1) family and will not make two (2) family contributions to both spouses or one (1) family contribution and one (1) individual contribution. MCHCP will make a seven-hundred-dollar (\$700) contribution to each spouse, to total one thousand four hundred dollars (\$1,400).

(C) Married, active employees who are MCHCP subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all medical information of the family unit. Failure to report an active employee spouse when newly hired and during open enrollment will result in a separate deductible and coinsurance for both active employees.

(D) During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance. The newborn will not be subject to a separate deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital.

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(D) Claims [may also] shall be paid at eighty percent (80%) if the subscriber requires covered services that are not available through network provider within [fifty (50)] one hundred (100) miles of his/her home. The participant must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is [not permanent.] for three (3) months. After three (3) months, the participant must contact the claims administrator to reassess network availability.

(E) Preventive care—network claims are paid at one hundred

percent (100%). Non-network claims are paid at sixty percent (60%) coinsurance after the deductible.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; [percentage amount coinsurance is reduced as a result of non-compliance with prior authorization] the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) Pharmacy benefits are subject to the [applicable medical plan] HDHP deductible and coinsurance.

**(6) A member does not qualify for the HDHP if they are covered under or enrolled in any of the following types of insurance plans or programs:**

**(A) Medicare;**

**(B) TRICARE;**

**(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only and dependent care section;**

**(D) Health reimbursement account (HRA); or**

**(E) The participant has veteran's benefits that have been used within the past three (3) months.**

**(7) A member may qualify for this plan even if s/he is covered by any of the following:**

**(A) Drug discount card;**

**(B) Accident insurance;**

**(C) Disability insurance;**

**(D) Dental insurance;**

**(E) Vision insurance; or**

**(F) Long-term care insurance.**

*AUTHORITY:* section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Amended: Filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Amended: Filed Dec. 22, 2010.

*PUBLIC COST:* This proposed amendment will cost state agencies or political subdivisions \$3,918,990 in the aggregate.

*PRIVATE COST:* This proposed amendment will cost private entities \$1,142,370 in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 2**

<b>Rule Number and Name:</b>	<b>22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan</b>	<b>\$ 3,918,990</b>

**III. WORKSHEET**

Estimated cost is the annual cost of the MCHCP providing the High Deductible Health Plan (HDHP) to all state employees and eligible retirees and dependents who enrolled for coverage under this plan for calendar year 2011.

**IV. ASSUMPTIONS**

- Total enrollment under the HDHP as of November 17, 2010 (data used the CY2010 projection);
- Calendar year 2011 membership in the HDHP remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Actual costs will vary based upon actual utilization of services.



**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>984 individuals enrolled in the MCHCP HDHP for CY 2011</b>	<b>Individuals enrolled in the MCHCP HDHP for CY 2011</b>	<b>\$1,142,370</b>

**III. WORKSHEET**

Estimated cost is the annual cost for all MCHCP subscribers' premium costs for coverage under the High Deductible Health Plan (HDHP) for calendar year 2011. In addition, members will pay the following deductible and coinsurance amounts based upon their individual utilization of covered benefits under the HDHP:

- \$1,200 individual network deductible
- \$2,400 family network deductible
- \$2,400 individual non-network deductible
- \$4,800 family non-network deductible
- 20 percent network coinsurance after deductible
- 40 percent non-network coinsurance after deductible
- \$2,400 individual network out-of-pocket maximum
- \$4,800 family network out-of-pocket maximum
- \$4,800 individual non-network out-of-pocket maximum
- \$9,600 family non-network out-of-pocket maximum

**IV. ASSUMPTIONS**

- Total enrollment in the HDHP as of November 17, 2010 (data used for the CY2011 projection);
- Calendar year 2011 membership in the HDHP remains relatively stable;

- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1) and (2).

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the Medicare Supplement Plan Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.*

(1) Eligibility—Subscribers and dependents covered in this plan must be enrolled in Medicare, and the subscribers must **be eligible to** receive a monthly retirement benefit from either the Missouri State Employees' Retirement System (MOSERS) or from the Public School Retirement System (PSRS), based on years of service. A subscriber may enroll in this plan when first eligible for Medicare **or during open enrollment.**

(2) Available services—The Medicare Supplement Plan *[covers coinsurance amounts on]* **includes the following benefits relating to** Medicare Parts A and B eligible benefits after the **applicable** Medicare deductibles are met~~[/.]~~:

**(A) Inpatient hospitalization—coverage for coinsurance for day sixty-one (61) through day ninety (90);**

**(B) Inpatient hospitalization—coverage for coinsurance for lifetime reserve days ninety-one (91) through one hundred fifty (150);**

~~[(A)]~~**(C) Inpatient [hospital care] hospitalization—covers** Medicare Part A coinsurance plus coverage for three hundred sixty-five (365) additional days after Medicare coverage ends;

~~[(B)]~~**(D) Medical costs—covers Medicare Part B coinsurance;**

~~[(C)]~~**(E) Blood—covers the first three (3) pints of blood each year;**  
and

~~[(D)]~~ *Prescription drug coverage.*

**(F) Hospice—coverage for the five percent (5%) coinsurance for Medicare-approved charges for inpatient respite care and five percent (5%) coinsurance up to a five-dollar (\$5) coinsurance maximum for prescription pain medications.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Amended: Filed Dec. 22, 2010.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions one hundred four thousand four hundred seventy dollars (\$104,470) in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities one hundred twenty thousand eight hundred eighteen dollars (\$120,818) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 2**

<b>Rule Number and Name:</b>	<b>22 CSR 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan</b>	<b>\$ 104,470</b>

**III. WORKSHEET**

Estimated cost is the annual cost of the MCHCP providing the Medicare Supplement Plan to all state eligible retirees and dependents who enrolled for coverage under this plan for calendar year 2011.

**IV. ASSUMPTIONS**

- Total enrollment under the Medicare Supplement Plan as of November 17, 2010 (data used the CY2011 projection);
- Calendar year 2011 membership in the Medicare Supplement Plan remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Actual costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>93 individuals enrolled in the MCHCP Medicare Supplement Plan for CY 2011</b>	<b>Individuals enrolled in the MCHCP Medicare Supplement Plan for CY 2011</b>	<b>\$120,818</b>

**III. WORKSHEET**

Estimated cost is the annual cost for all MCHCP subscribers' premium costs for coverage under the Medicare Supplement Plan for calendar year 2011. In addition, members will pay the following deductibles and services not covered by Medicare:

- Long-term care
- Hearing aids
- Private-duty nursing
- Skilled nursing facility coinsurance for days 21-100
- Part A hospital deductible
- Part B deductible
- Foreign travel emergency coverage
- At-home recovery (home health aide services)
- Preventive medical care

**IV. ASSUMPTIONS**

- Total enrollment in the Medicare Supplement Plan as of November 17, 2010 (data used for the CY2011 projection);
- Calendar year 2011 membership in the Medicare Supplement Plan remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary;

- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1) and (2).

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the Medical Plan Benefit Provisions and Covered Charges for participation in the Missouri Consolidated Health Care Plan.*

(1) Benefit Provisions Applicable to the *[HMO, Copay,]* PPO 300, **PPO 600**, and **High Deductible Health Plan (HDHP)** Plans.

*[(A)] Subject to the plan provisions, [and] limitations, and [the written application] enrollment of the employee, the benefits are payable for covered charges incurred by a participant while covered under the plans, provided the deductible requirement, if any, is met.*

*[(B) Any deductible requirement applies each calendar year to covered charges. The requirement is met as soon as covered charges incurred in a calendar year, which are not paid in part or in whole by the plan, equals the deductible amount.*

*(C) Any family deductible requirement is met as soon as covered charges in a calendar year, which are not paid in part or in whole by the plan, equals the family deductible requirement.*

*(D) The total amount of benefits payable for all covered charges incurred non-network during an individual's lifetime shall not exceed the lifetime maximum.]*

(2) Covered Charges Applicable to the *[HMO, Copay,]* PPO 300, **PPO 600**, and HDHP Plans.

(A) Only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a noncovered service, and which are:—

1. Prescribed by a doctor or provider for the therapeutic treatment of injury or sickness;
2. To the extent they do not exceed any limitation;
3. Not excluded by the limitations; and
4. For not more than the usual, reasonable, and customary charge, as determined by the claims administrator for the services provided, will be considered covered charges.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, reasonable, and customary, the claims administrator will consider the following:

1. The medical benefits or supplies usually rendered or prescribed for the condition; and
2. The usual, reasonable, and customary charges in the area in which services and/or supplies are provided.

**(C) A physician visit to seek a second opinion is a covered service.**

**(D) Plan benefits for the PPO 300, PPO 600, and HDHP plans are as follows:**

<b>STATE BENEFITS</b>	
<b>Allergy Serum</b> <b>Multi-dose vial</b>	<b>No coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers or air ventilation system cleaning.</b>
<b>Ambulance Service</b> <b>Non-emergency air or ground excluded unless prior authorization received from medical plan.</b>	<b>Use of air ambulance or medical helicopter service from any continent returning to the U.S. is excluded.</b>
<b>Applied Behavioral Analysis for Autism</b> <b>For children younger than age 19</b>	<b>The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of observation, measurement and functional analysis of the relationship between environment and behavior.</b>  <b>\$40,000 annual limit. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary.</b>  <b>Prior authorization by medical plan required.</b>
<b>Birth Control Prescriptions</b>	
<b>Birth Control Devices and Injections</b> <b>Administered in the physician's office.</b>	
<b>Cardiac and Pulmonary Rehabilitation</b> <b>Up to 36 visits within a 12-week period per incident</b>	<b>Prior authorization by medical plan required after 36 visits within a 12-week period.</b>
<b>Chelation Therapy</b> <b>Limited to treatment of lead poisoning in children as recommended by Missouri Department of Health and Senior Services.</b>	
<b>Chiropractic Services</b> <b>Up to 26 visits annually</b>	<b>Prior authorization by medical plan required after 26 visits annually.</b>
<b>Cochlear Implant Device</b>	<b>Prior authorization by medical plan required.</b>
<b>Colonoscopy</b>	
<b>Convenient Care Clinic (CCC)</b>	



**Dental Care/Accidental Injury**

Treatment to reduce trauma and restorative services only when the result of accidental injury to sound, natural teeth and tissue that are viable, functional and free of disease. Oral surgery is covered when medically necessary as a direct result of injury, tumors or cysts. Treatment must be initiated within 60 days of accident.

No coverage for dental care, including oral surgery, as a result of poor dental hygiene.

Prior authorization by medical plan required.

**Durable Medical Equipment (DME)/Medically Necessary Disposable Supplies**

Basic equipment that meets medical needs. DME includes, but is not limited to, augmentative communication devices and manual and powered mobility devices. Includes repair and replacement due to normal wear and tear, if there is a change in medical condition or if growth-related. Disposable supplies that do not withstand prolonged use and are periodically replaced include, but are not limited to, colostomy and ureterostomy bags and prescription compression stockings.

No coverage for non-reusable disposable supplies including but not limited to bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinence pads, irrigating kits, pressure leotards, surgical leggings and support hose, over-the-counter medications and supplies including oral appliances.

Prior authorization by medical plan required for durable medical equipment over \$1,500 and/or rentals over \$500/month.

Prescription compression stockings are limited to two pairs or four individual stockings per plan year.

**Emergency Room Services**

If admitted to hospital, may be required to transfer to network facility for maximum benefit. Paid as network benefit.

**Enteral Feedings (Tube Feeding)**

Nutritional supplements that are prescribed by a physician and administered through enteral feedings, provided they are the sole source of nutrition and the member has a permanent condition, or partial nutrition during transition. This includes nutritional and electrolyte supplements and supplies related to enteral feedings (for example, feeding tubes, pumps and other materials used to administer enteral feedings).

**Flu Shot/Nasal Spray (FluMist®)**

Covered at 100% when administered in a network physician's office. When shot is obtained elsewhere, the member must submit a receipt and a Non-Network Flu Shot Reimbursement form to medical plan to receive reimbursement up to \$25. Multiple vaccinations covered if recommended by the Missouri Department of Health and Senior Services or by the Centers for Disease Control and Prevention.

**Genetic Testing or Counseling**

Genetic testing or counseling as part of treatment for a medical condition

No coverage for testing based on family history.

Prior authorization by medical plan required.

<b>Hair Analysis and Prostheses</b> Limited to prostheses and expenses for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata or alopecia totalis for children 18 years of age or younger. Annual maximum \$200. Lifetime maximum \$3,200.  No coverage for services related to the analysis of hair unless used as a diagnostic tool to determine poisoning.
<b>Hearing Aids (Per Ear)</b> Covered once every two years. Member pays coinsurance amount per hearing aid. If hearing aid cost exceeds the amount listed below, member is also responsible for charges over that amount.  Conventional: \$1,000 Programmable: \$2,000 Digital: \$2,500 BAHA: \$3,500
<b>Hearing Testing</b> One hearing test per year. Additional hearing tests are covered if recommended by physician.
<b>Home Health Care/Palliative Services</b>  Prior authorization by medical plan required.
<b>Hospice Care</b> <b>Inpatient or Outpatient</b> Includes bereavement and respite care.  Prior authorization by medical plan required.
<b>Hospital Benefits - Inpatient Room and Board</b> Based on semi-private room <ul style="list-style-type: none"> <li>• Medical (including outpatient services)</li> <li>• Mental Health (including outpatient services)</li> <li>• Chemical Dependency (including outpatient services)</li> <li>• Observation for Medical, Mental Health or Chemical Dependency</li> </ul> Except for observation, prior authorization by medical plan required.
<b>Immunizations (Age-appropriate Adult and Pediatric)</b> Specified schedule of immunizations including, but not limited to, polio, rubella, measles, mumps, tetanus, whooping cough, diphtheria, hepatitis A and B, haemophilus influenzae type B (Hib), human papillomavirus, shingles, chicken pox, meningitis and pneumonia.  Not covered when requested by third party or for travel.  Immunizations required by the Missouri Department of Health and Senior Services or recommended by the Centers for Disease Control and Prevention.
<b>Injections and Infusions</b> Administered in the physician's office.
<b>Lab and X-ray</b>
<b>Mammograms</b> One mammogram per year. Additional mammograms are covered if recommended by physician.
<b>Mastectomies</b> No time frame on receiving reconstructive surgery or prostheses after mastectomies necessary to restore symmetry, as recommended by physician.

**Maternity Coverage**

Newborns and their mothers are allowed hospital stays of at least 48 hours after normal birth and 96 hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two-visit minimum, at least one in the home.

Prior authorization by medical plan required for maternity stays longer than 48 hours (normal delivery) or 96 hours (C-section).

**Mental Health/Chemical Dependency (Office Visit)**

**Nutrient Supplements**

Formula and low-protein modified food products recommended by physician and limited only to treatment of Phenylketonuria (PKU) or any inherited disease of amino and organic acids

**Nutritional Counseling**

Up to three sessions annually with registered dietitian, not limited by diagnosis. Up to three additional sessions considered with referral and medical diagnosis.

Prior authorization by medical plan required after three sessions annually.

**Office Visit**

**Primary Care Physicians**

**Specialists**

**Orthotics****Therapeutic Shoes for Diabetics**

Therapeutic shoes, inserts, and/or modifications to therapeutic shoes are covered if the following criteria are met:

- The patient has diabetes mellitus; and
- The patient has one or more of the following conditions:
  - Previous amputation of the other foot, or part of either foot, or
  - History of previous foot ulceration of either foot, or
  - History of pre-ulcerative calluses of either foot, or
  - Peripheral neuropathy with evidence of callus formation of either foot, or
  - Foot deformity of either foot, or
  - Poor circulation in either foot; and
- The certifying physician who is managing the patient's systemic diabetes condition has certified that indications noted in this *Therapeutic Shoes for Diabetics* section are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes.

For adult patients meeting these criteria, coverage is limited to one of the following within one year:

- One pair of custom molded shoes (which includes inserts provided with these shoes) and 2 additional pairs of inserts; or
- One pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes).

Separate inserts may be covered and dispensed independently of diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed. This footwear must meet the definitions found in this policy for depth shoes or custom molded shoes. See Orthopedic Footwear benefit.

There is no separate payment for the fitting of the shoes, inserts, or modifications or for the certification of need or prescription of the footwear.

**Spinal Orthoses**

A thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the trunk; or
- To facilitate healing following an injury to the spine or related soft tissues; or
- To facilitate healing following a surgical procedure on the spine or related soft tissue; or
- To otherwise support weak spinal muscles and/or a deformed spine.

**Helmets**

Helmets are provided when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living. These devices are not provided for use during sports-related activities.

**Cranial Orthosis for Plagiocephaly**

Plagiocephaly describes an asymmetrically shaped head. Synostotic plagiocephaly (craniosynostosis) is due to the premature closure of the cranial sutures. In non-synostotic plagiocephaly, also referred to as positional or deformational, the cranial sutures remain open. Cranial orthosis is the use of a special helmet or band on the head, which aids in molding the shape of the cranium to normal.

Dynamic orthotic cranioplasty, which may also be referred to as cranial molding, molding helmet, cranial banding, or cranial orthosis, is considered medically necessary only as an adjunct to operative therapy following surgery for craniosynostosis. Molding helmet therapy, including dynamic orthotic cranioplasty, is not a covered benefit for the non-operative management of positional or non-synotic plagiocephaly.

Initial reimbursement shall cover any subsequent revisions.

**Cervical Orthoses**

**A cervical orthosis is covered when it is ordered for one of the following indications:**

- To reduce pain by restricting mobility of the neck; or
- To facilitate healing following an injury to the cervical spine or related soft tissues; or
- To facilitate healing following a surgical procedure on the cervical spine or related soft tissue; or
- To otherwise support weak cervical muscles and/or a deformed cervical spine.

**Hip Orthoses**

**A hip orthosis is covered when it is ordered for one of the following indications:**

- To reduce pain by restricting mobility of the hip; or
- To facilitate healing following an injury to the hip or related soft tissues; or
- To facilitate healing following a surgical procedure on the hip or related soft tissue; or
- To otherwise support weak hip muscles and/or a hip deformity.

**Knee Orthoses**

**A knee orthosis is covered when it is ordered for one of the following indications:**

- To reduce pain by restricting mobility of the knee; or
- To facilitate healing following an injury to the knee or related soft tissues; or
- To facilitate healing following a surgical procedure on the knee or related soft tissue; or
- To otherwise support weak knee muscles and/or a knee deformity.

**These devices are not provided solely for use during sports-related activities.**

**Ankle-Foot/Knee-Ankle-Foot (AFO) Orthoses**

**AFOs Not Used During Ambulation**

**A static AFO is covered if the following criteria are met:**

- Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a non-fixed contracture); and,
- Reasonable expectation of the ability to correct the contracture; and,
- Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and,
- Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; OR
- The patient has plantar fasciitis.

**If a static AFO is used for the treatment of a plantar flexion contracture, the pre-treatment passive range of motion must be measured with a goniometer and documented in the medical record. There must be documentation of an appropriate stretching program carried out by professional staff or caregiver. A static AFO and replacement interface will be denied as not medically necessary if the contracture is fixed. A static AFO and replacement interface will be denied as not medically necessary for a patient with a foot drop but without an ankle flexion contracture. A component of a static AFO that is used to address positioning of the knee or hip will be denied as not medically necessary because the effectiveness of this type of component is not established.**

**If a static AFO is covered, a replacement interface is covered as long as the patient continues to meet indications and other coverage rules for the splint. Coverage of a replacement interface is limited to a maximum of one (1) per 6 months. Additional interfaces will be denied as not medically necessary.**

**A foot drop splint/recumbent positioning device and replacement interface will be denied as not medically necessary in a patient with foot drop who is non-ambulatory because there are other more appropriate treatment modalities.**

**AFOs and KAFOs Used During Ambulation**

**AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally.**

**Knee-ankle-foot orthoses (KAFO) are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required.**

**If the basic coverage criteria for an AFO or KAFO are not met, the orthosis will be denied as not medically necessary. AFOs and KAFOs that are molded-to-patient-model, or custom-fabricated, are**

covered for ambulatory patients when the basic coverage criteria listed above and one of the following criteria are met:

- The patient could not be fit with a prefabricated AFO, or
- The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months), or
- There is a need to control the knee, ankle or foot in more than one plane, or
- The patient has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury, or
- The patient has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

Current Procedural Terminology (CPT) L-coded additions to AFOs and KAFOs will be denied as not medically necessary if either the base orthosis is not medically necessary or the specific addition is not medically necessary.

#### Foot Orthosis

Custom, removable foot orthoses are considered medically necessary for members who meet the following criteria:

- Member has any of the following conditions:
  - Adults (skeletally mature feet):
    - Acute plantar fasciitis
    - Acute sport-related injuries (including: diagnoses related to inflammatory problems; e.g., bursitis, tendonitis)
    - Calcaneal bursitis (acute or chronic)
    - Calcaneal spurs (heel spurs)
    - Conditions related to diabetes (see section above on therapeutic shoes for diabetes for a complete list of medically necessary diagnoses)
    - Inflammatory conditions (i.e., sesamoiditis; submetatarsal bursitis; synovitis; tenosynovitis; synovial cyst; osteomyelitis; and plantar fascial fibromatosis)
    - Medial osteoarthritis of the knee (lateral wedge insoles)
    - Musculoskeletal/arthropathic deformities (including: deformities of the joint or skeleton that impairs walking in a normal shoe; e.g. bunions, hallux valgus, talipes deformities, pes deformities, anomalies of toes)
    - Neurologically impaired feet (including: neuroma; tarsal tunnel syndrome; ganglionic cyst; and neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease)
    - Vascular conditions (including: ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), chronic thrombophlebitis).
  - Children (skeletally immature feet):
    - Hallux valgus deformities
    - In-toe or out-toe gait
    - Musculoskeletal weakness (e.g., pronation, pes planus)
    - Structural deformities (e.g., tarsal coalitions)
    - Torsional conditions (e.g., metatarsus adductus, tibial torsion, femoral torsion)

#### Orthopedic Footwear

Orthopedic footwear is covered for adults if it is an integral part of a covered leg brace. Oxford shoes are covered in these situations. Other shoes, e.g. high top, depth inlay or custom for non-diabetics, etc., are also covered if they are an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace. Heel replacements, sole replacements, and shoe transfers involving shoes on a covered brace are also covered. Inserts and other shoe modifications are covered if they are on a shoe that is an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace.

**A shoe and related modifications, and heel/sole replacements, are covered only when the shoe is an integral part of a brace. A matching shoe which is not attached to a brace is non-covered. Shoes which are incorporated into a brace must be billed by the same supplier billing for the brace.**

**Upper Limb Orthoses**

**An upper limb orthosis is covered when it is ordered for one of the following indications:**

- To reduce pain by restricting mobility of the joint(s)
- To facilitate healing following an injury to the joint(s) or related soft tissues
- To facilitate healing following a surgical procedure on the joint(s) or related soft tissue

**Elastic Supports**

**Elastic supports are covered when they are ordered for one of the following indications:**

- Severe or incapacitating vascular problems, such as
  - acute thrombophlebitis
  - massive venous stasis'
  - pulmonary embolism
- Venous insufficiency
- Varicose veins
- Edema of lower extremities
- Edema of pregnancy
- Lymphedema

**Trusses**

**Trusses are covered when a hernia is reducible with the application of a truss.**

**Orthotic-Related Supplies**

**Orthotic-related supplies are covered when the device with which it is used is covered and they are necessary for the function of the orthotic device.**

**Cast Boot, Post-Operative Sandal or Shoe, Healing Shoe**

**A cast boot or post-operative sandal or shoe is covered when it is medically necessary for one of the following indications:**

- to protect a cast from damage during weight-bearing activities following injury or surgery;
- to provide appropriate support and/or weight-bearing surface to a foot following surgery;
- to promote good wound care and healing via appropriate weight distribution and foot protection; or
- when the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

**Specific Exclusions**

**Non-covered devices and supplies include, but are not limited to, all of the following:**

- Experimental or Investigational devices
- Items for the patient's comfort or convenience or for the convenience of the patient's caregiver(s)
- Items to have on hand for backup or duplicates to have available at various locations
- Devices and supplies for residents of nursing facilities
- Equipment or supplies covered by another agency

**Replacing Orthotic Devices**

**When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item. A replacement is subject to review of medical necessity. The plan will take into account the anticipated life expectancy of the device.**

**Prior authorization by medical plan required for orthotics over \$1,000**

**Outpatient Diagnostic Procedures**

**Including, but not limited to, diagnostic sigmoidoscopies, endoscopies, sleep studies, ultrasounds, electroencephalograms (EEGs) and electrocardiograms (EKGs)**

**Oxygen  
Outpatient**

Go to **DURABLE MEDICAL EQUIPMENT** in this section.

**Prior authorization by medical plan required.**

**Physical, Speech and Occupational Therapy and Rehabilitation Services - Outpatient**

Up to 60 combined visits allowed per incident if showing significant improvement. Aquatic therapy must be performed by physical therapist to be covered.

**Speech Therapy:**

Covered as medically necessary for either of the following:

- A prescribed course of speech therapy by an appropriate healthcare provider for the treatment of a severe impairment of speech/language and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests that measure the extent of the impairment, performance deviation, and language and pragmatic skills assessment levels.
- A prescribed course of voice therapy by an appropriate healthcare provider for a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery).

When all of the following criteria are met:

- The treatment being recommended has the support of the treating physician;
- The therapy being ordered requires the one-to-one intervention and supervision of a speech-language pathologist;
- The therapy plan includes specific tests and measures that will be used to document significant progress every two weeks;
- Meaningful improvement is expected from the therapy and
- The treatment includes a transition from one-to-one supervision to an individual or caregiver provided maintenance program upon discharge.

Speech or voice therapy is not covered in any of the following situations:

- Any computer-based learning program for speech or voice training purposes
- School speech programs
- Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy)
- Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs)
- Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver
- Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work
- Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences
- Therapy or treatment provided to improve or enhance job, school or recreational performance
- Long-term rehabilitative services when significant therapeutic improvement is not expected

**Physical Therapy:**



**Covered as a prescribed course of physical therapy by an appropriate healthcare provider as medically necessary when all of the following criteria are met:**

- The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect or surgery;
- The program is expected to result in significant therapeutic improvement over a clearly defined period of time and
- The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.

**Physical therapy is not covered for the following:**

- Treatment provided to prevent or slow deterioration in function or prevent reoccurrences
- Treatment intended to improve or maintain general physical condition
- Long-term rehabilitative services when significant therapeutic improvement is not expected
- Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g. occupational therapy)
- Work hardening programs
- Back school
- Vocational rehabilitation programs and any program with the primary goal of returning an individual to work
- Group physical therapy (because it is not one-on-one, individualized to the specific person's needs)
- Services for the purpose of enhancing athletic performance or for recreation

**Occupational Therapy:**

**Covered as prescribed course of occupational therapy by an appropriate healthcare provider as medically necessary when all of the following criteria are met:**

- The program is designed to improve or compensate for lost or impaired physical functions, particularly those impacting activities of daily living, resulting from illness, injury, congenital defect, or surgery;
- The program is expected to result in significant therapeutic improvement over a clearly defined period of time and
- The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.

**Occupation Therapy is not covered for the following:**

- Treatment provided to prevent or slow deterioration in function or prevent reoccurrences
- Treatment intended to improve or maintain general physical condition
- Long-term rehabilitative services when significant therapeutic improvement is not expected
- Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g. physical therapy)
- Work hardening programs
- Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work
- Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs)
- Driving safety/driver training

**Prior authorization by medical plan required after 60 combined visits per incident.**

**Physician Charges**

**Preventive Services**

- Services recommended by the U.S. Preventive Services Task Force (categories A and B)
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration
- Preventive care and screenings for women supported by the Health Resources and Services Administration

**Annual physical exams (Well man, woman and child) -**

**one per calendar year**

**Age-specific cancer screenings:**

- Mammograms
- Pap smears
- Prostate cancer screenings
- Colorectal screenings
- Colonoscopy and sigmoidoscopy screenings

**For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.**

**Prostheses (Prosthetic Devices)**

**Basic equipment that meets medical needs**

**Repair and replacement not covered unless due to normal wear and tear, if there is a change in medical condition or if growth-related.**

**Prior authorization by medical plan required for prostheses over \$1,000.**

**Skilled Nursing Facility**

**Benefits are limited to 120 days per calendar year.**

**Prior authorization by medical plan required.**

**Surgery (Inpatient and Outpatient)**

**Includes sterilization**

**Prior authorization by medical plan required for outpatient surgeries:**

- Potential cosmetic surgery
- Sleep Apnea surgery
- Implantable Stimulators
- All outpatient surgeries with procedure codes ending in T (temporary codes used for data collection, experimental, investigational or unproven surgeries)
- Outpatient spinal surgeries including but not limited to artificial disc replacement, fusions, non-pulsed radiofrequency denervation, vertebroplasty/kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure.

**Oral surgery**

- Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological exams
- Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth
- Reduction of fractures and dislocations of the jaw
- Excision of exostosis of jaws and hard palate
- External incision and drainage of cellulitis
- Incision of accessory sinuses, salivary glands or ducts
- Frenectomy

**Transplants**

**When neither experimental nor investigational and medically necessary: bone marrow, cornea, kidney, liver, heart, lung, pancreas, intestinal or any combination. Includes services related to organ procurement and donor expenses if not covered under another plan.**

**Contact medical plan for arrangements, prior authorization and transplant network.**

**Travel, if approved, is limited to \$10,000 maximum per transplant.**

**Network**

**Includes travel and lodging allowance for recipient and his or her immediate family travel companion (younger than 19, both parents) if transplant facility is more than 100 miles from residence.**

**Lodging: Maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to [www.gsa.gov](http://www.gsa.gov) for per diem rates.**

**Travel: IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).**

**Meals: Not covered.**

**Prior authorization by medical plan required.**

**Non-network**

**Reimbursement limited to maximum schedule. Charges above the maximum are your responsibility and do not apply to your deductible or out-of-pocket maximum.**

**Travel, lodging and meals not covered.**

**Prior authorization by medical plan required.**

**Urgent Care**

**Paid as network benefit.**

**Vision - Routine Exam (Including refractions)**

**One per covered person per calendar year.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Amended: Filed Dec. 22, 2010.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions \$384,770,124 in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities \$118,646,208 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 2**

<b>Rule Number and Name:</b>	<b>22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan</b>	<b>\$384,770,124</b>

**III. WORKSHEET**

Estimated cost is the annual cost of the MCHCP providing health care plans to all state employees and eligible retirees and dependents for calendar year 2011.

**IV. ASSUMPTIONS**

- Total enrollment as of November 17, 2010 (data used the CY2011 projection);
- Calendar year 2011 membership remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary.
- Actual costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>99,648 individuals enrolled in MCHCP plans for CY 2011</b>	<b>Individuals enrolled in MCHCP plans for CY 2011</b>	<b>\$118,646,208</b>

**III. WORKSHEET**

Estimated cost is the annual cost for all MCHCP subscribers' premium costs for calendar year 2011.

**IV. ASSUMPTIONS**

- Total enrollment as of November 17, 2010 (data used the CY2011 projection);
- Calendar year 2011 membership remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary, and insured premiums developed by Mercy Health Plans;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan, and HDHP[, Copay Plan, and HMO Plan] Limitations.** The Missouri Consolidated Health Care Plan is amending the rule title and the purpose; deleting sections (2), (33), (48), (50), (52), and (57); adding sections (3), (6), (7), (9)-(11), (15), (16), (30), (33), (37), (41), (42), (48), (54), (56), and (63); amending sections (12), (18)-(20), (35), (40), (43), (49), (59), (64), and (65); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to limitations of the PPO 300 Plan, PPO 600 Plan, and HDHP limitations of the Missouri Consolidated Health Care Plan.*

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 300 Plan, PPO 600 Plan, and HDHP[, Copay, and HMO Plan] Limitations of the Missouri Consolidated Health Care Plan.*

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges[, or within any of the sections of this rule]. **In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein.**

*[(2) If applicable, all hospitalizations, outpatient treatment for chemical dependency, or mental and nervous disorder that do not receive prior authorization as described in 22 CSR 10-2.045, reimbursement will be reduced by ten percent (10%) of reasonable and customary charges.]*

*[(3)](2) Abortion—other than situations where the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.*

**(3) Acts of war—injury or illness caused, or contributed to, by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.**

**(6) Assistant surgeon services—not covered unless determined to meet the clinical eligibility for coverage under the plan.**

**(7) Athletic trainer services—services by a licensed athletic trainer not covered.**

*[(6)](8) Autopsy.*

**(9) Bariatric procedures—not covered except for members who have undergone bariatric procedures before December 31, 2010, that were approved by the medical plan will receive follow-up care until December 31, 2011. Revisions and corrections of bariatric procedures are covered only when the revision is used to treat life-threatening complications (e.g., wound infection, abscess, dehiscence, gastric leaking, and embolism).**

**(10) Blood donor expenses—not covered.**

**(11) Blood pressure cuffs/monitors—not covered.**

*[(7)](12) Blood storage[,]***—not covered**, including whole blood, blood plasma, and blood products.

*[(8)](13) Breast augmentation mammoplasty—not covered unless associated with breast surgery following a medically necessary mastectomy incurred secondary to active disease.*

*[(9)](14) Care received without charge.*

**(15) Charges resulting from the failure to appropriately cancel a scheduled appointment.**

**(16) Childbirth classes.**

*[(10)](17) Comfort and convenience items.*

*[(11)](18) Cosmetic, plastic, reconstructive, or restorative surgery—unless medically necessary to repair a functional disorder caused by disease[,]* **or injury**, or congenital defect or abnormality (for a participant under the age of nineteen (19)), or to restore symmetry following a mastectomy.

*[(12)](19) Custodial or domiciliary care—includes services and supplies that assist members in the activities of daily living like walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets [and]; supervision of medication that is usually self-administered; or other services that can be provided by persons without the training of a health care provider.*

*[(13)](20) Dental—treatment must be initiated within sixty (60) days of accident. Limited to treatment of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of disease.* Oral surgery is covered only when medically necessary as a direct result from injury, tumors, or cysts. Dental care, including oral surgery, as a result of poor dental hygiene is not covered. Extractions of bony or partial bony impactions are excluded.

*[(14)](21) Durable medical equipment and disposable supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings, and support hose. Over-the-counter medications and supplies. Prescription compression stockings are limited to two (2) pairs of four (4) individual stockings per plan year.*

*[(15)](22) Educational or psychological testing—not covered unless part of a treatment program for covered services.*

*[(16)](23) Examinations requested by a third party.*

*[(17)](24) Excessive charges—any otherwise eligible expenses that exceed the maximum allowance or benefit limit.*

*[(18)](25) Exercise equipment.*

*[(19)](26) Experimental services or investigational services—experimental or investigational services, procedures, supplies, or drugs as determined by the claims administrator are not covered, except clinical trials for cancer treatment as specified by law.*

*[(20)](27) Eye glasses and contact lenses—charges incurred in connection with the fitting of eye glasses or contact lenses except for initial placement immediately following cataract surgery.*

*[(21)](28) Eye services—health services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.*

*[(22)](29) Services obtained at a government facility—not covered if care is provided without charge.*



**(30) Gender reassignment—health services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment.**

*[(23)](31) Hair analysis, wigs, and hair transplants—services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also, hairstyling wigs, hairpieces, and hair prostheses, including those ordered by a participating provider, are not covered. Such items and services are not covered except for members ages eighteen (18) and under with alopecia as specified by law. Subject to two hundred dollar (\$200) annual maximum and three thousand two hundred dollar (\$3,200) lifetime maximum.*

*[(24)](32) Health and athletic club membership—including costs of enrollment.*

**(33) Home births.**

*[(25)](34) Immunizations requested by third party or for travel.*

*[(26)](35) Infertility treatment.—Infertility treatments are limited to in-vivo (intrauterine, intracervical, intravaginal fertilization). Those health services and associated expenses for the treatment of infertility are not covered, including reversal of voluntary sterilization, intracytoplasmic sperm injection (ICSI), in vitro fertilization, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT) procedures; embryo transport; donor sperm and related cost for collection; no cryopreservation of sperm or eggs; and non-medically necessary amniocentesis.]*

*[(27)](36) Level of care, if greater than is needed for the treatment of the illness or injury.*

**(37) Long-term care.**

*[(28)](38) Medical care and supplies—not to the extent that they are payable under—*

*(A) A plan or program operated by a national government or one (1) of its agencies; or*

*(B) Any state's cash sickness or similar law, including any group insurance policy approved under such law.*

*[(29)](39) Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the participant, such as a spouse, parent, child, sibling, or brother/sister-in-law.*

*[(30)](40) Military service connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.*

**(41) Never events—twenty-eight (28) occurrences on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting. They are defined as adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.**

**(42) Nocturnal enuresis alarm.**

*[(31)](43) Non-network providers—subject to **higher** deductible and non-network coinsurance.*

*[(32)](44) Not medically necessary services—with the exception of preventive services.*

*[(33) Obesity—medical and surgical intervention is not covered, unless the member meets the definition of severe morbid obesity as defined in 22 CSR 10-2.010 and satisfies all requirements described in the plan. Bariatric surgery will only be covered when prior authorization is received from the medical plan.*

*(A) Bariatric surgery additional qualifying criteria—*

*1. Presence of severe morbid obesity that has persisted for at least five (5) years defined as body mass index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions approved by the plan based on clinical review;*

*2. Member must be eighteen (18) years of age or older;*

*3. Documented evidence of at least two (2) failed attempts at weight loss each with a minimum duration of at least six (6) months with the member achieving at least a ten percent (10%) weight loss and meeting the following additional criteria: one (1) attempt must be in a physician-supervised weight loss program and fully documented in the physician's record; the program must use a multidisciplinary approach including dietician consultation, low-calorie diet, increased physical activity, and behavioral modification; nationally recognized program such as Jenny Craig or Weight Watchers (This does not include self-directed low-calorie diets such as the Atkins Diet or South Beach Diet.); and the most recent attempt must have been within the twelve (12)-month period prior to the requested surgery;*

*4. Documented evidence the member is on a nutrition and exercise program immediately prior to the surgery request;*

*5. Evidence the member and the attending physician have a life-long plan for compliance with lifestyle modification requirements;*

*6. Documentation the member has completed a psychological evaluation and, if appropriate, behavior modification and should be free of major psychiatric diagnosis or a current behavior which would significantly reduce long-term effectiveness of the proposed treatment; and*

*7. Procedure must be performed at a Centers of Excellence (COE) facility for Bariatric Surgery as determined by the Centers for Medicare and Medicaid Services.*

*(B) Network services are limited to one (1) operative procedure for the treatment of obesity per lifetime. Non-network obesity services are not covered.*

*(C) Revisions and corrections of bariatric procedures are covered only when the revision or correction is used to treat life-threatening complications (e.g., wound infection, abscess, dehiscence, gastric leaking, and embolism). Coverage is limited to the following bariatric procedures: Roux-en-Y Gastric Bypass—open and laparoscopic (RYGBP), Laparoscopic Adjustable Gastric Banding (LAGB), and Open and Laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS).]*

*[(34)](45) Orthognathic surgery.*

*[(35)](46) Orthoptics.*

*[(36)](47) Other charges—no coverage for charges that would not be incurred if the subscriber was not covered. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan. Miscellaneous service charges—telephone consultations,*

charges for failure to keep scheduled appointment (unless the scheduled appointment was for a mental health service), or any late payment charge.

**(48) Outpatient birthing centers.**

*[(37)](49)* Over-the-counter medications—except for insulin and drugs recommended by the U.S. Preventive Services Task Force (Categories A and B) as prescribed by a physician and included on the formulary through the pharmacy benefit.

*[(38)](50)* Over-the-counter supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings, and support hose.

*[(39)](51)* Physical fitness.

*[(40)](52)* Physical, speech, and occupational therapy—health services and associated expenses for development delay. Treatment for disorders relating to delays in learning, motor skills, and communications.

*[(41)](53)* Private duty nursing.

**(54) Prognathic and maxillofacial surgery.**

*[(42)](55)* Prosthetic repair or replacement—not covered unless due to normal wear and tear, if there is a change in medical condition, if growth related, or medically necessary.

**(56) Self-inflicted injuries—not covered unless related to a mental diagnosis.**

*[(43)](57)* Services not specifically included as benefits.

*[(44)](58)* Services rendered after termination of coverage—those services otherwise covered under the agreement, but rendered after the date coverage under the agreement terminates, including services for medical conditions arising prior to the date individual coverage under the agreement terminates.

*[(45)](59)* Stimulators (for bone growth)—not covered unless **prior** authorized by claims administrator **and clinical eligibility is met**.

*[(46)](60)* Surrogacy—pregnancy coverage is limited to plan member.

*[(47)](61)* Temporomandibular Joint Syndrome (TMJ).

*[(48)]* *Third-party examinations.]*

*[(49)](62)* Tobacco cessation—patches and gum are not covered. *[There is a limited benefit available under the pharmacy benefit.]*

**(63) Transplant benefits at a non-network facility. Non-network facility charges and payments for transplants are limited to the following maximum only:**

- (A) Allogenic Bone Marrow—\$143,000;
- (B) Autologous Bone Marrow—\$121,000;
- (C) Heart—\$128,000;
- (D) Heart and Lung—\$133,000;
- (E) Lung—\$151,000;
- (F) Kidney—\$54,000;
- (G) Kidney and Pancreas—\$97,000; and
- (H) Liver—\$153,000.

*[(50)]* *Transplants—double listing—payment only for one (1) evaluation up to time of actual transplant.]*

*[(51)](64)* Transplants—travel expense—requires authorization from medical plan. Limited to ten thousand dollar (\$10,000) maximum per transplant when accessing network services. **Travel expenses include travel and lodging allowance for recipient and his/her immediate family travel companion. When a participant is younger than nineteen (19) years of age, travel expenses are covered for both parents. Transplant facility must be more than one hundred (100) miles from the recipient's residence. Meals are not covered.**

*[(52)]* *Transsexual surgery—health services and associated expenses in the transformation operations regardless of any diagnosis or gender role disorientation or psychosexual orientation or any treatment or studies related to sex transformation. Also excludes hormonal support for sex transformation.]*

*[(53)](65)* Travel expenses—not covered *[unless authorized by claims administrator]* **except for transplants in a network facility.**

*[(54)](66)* Trimming of nails, corns, or calluses—not covered except for persons being treated for diabetes, peripheral vascular disease, or blindness.

*[(55)](67)* Usual, Customary, and Reasonable (UCR)—charges exceeding UCR are not covered, as applicable to the non-network benefit.

*[(56)](68)* Vitamins and nutrients—limited to prenatal agents for pregnancy, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents through the pharmacy benefit.

*[(57)]* *War or insurrection—liability to provide services limited in the event of a major disaster, epidemic, riot, or other circumstances beyond the control of the plan.]*

*[(58)](69)* Workers' compensation—charges for services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other **similar** legislation *[of similar program]*.

*AUTHORITY: section 103.059, RSMo 2000 and section 103.080.3, RSMo Supp. [2009] 2010. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Amended: Filed Dec. 22, 2010.*

**PUBLIC COST:** *This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

**PRIVATE COST:** *This proposed amendment will cost private entities two (2) million dollars in the aggregate.*

**NOTICE TO SUBMIT COMMENTS:** *Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan, and HDHP Limitations</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>99,648 individuals enrolled in MCHCP plans for CY 2011</b>	<b>Individuals enrolled in MCHCP plans for CY 2011</b>	<b>\$ 2,000,000</b>

**III. WORKSHEET**

Estimated cost is the annual cost for MCHCP subscribers' for bariatric and infertility non-covered services under the MCHCP medical plans for calendar year 2011.

**IV. ASSUMPTIONS**

- Estimated annual cost for bariatric services is \$1,000,000;
- Estimated annual cost for infertility services is \$1,000,000;
- Other changes are clarifications and are not new limitations.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED RESCISSION**

**22 CSR 10-2.064 HMO Summary of Medical Benefits.** This rule established the policy of the board of trustees in regard to the HMO Summary of Medical Benefits of the Missouri Consolidated Health Care Plan.

*PURPOSE:* This rule is being rescinded because it is no longer needed.

*AUTHORITY:* section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the *Code of State Regulations*. Emergency rescission filed Dec. 20, 2010, effective Jan. 1, 2011, expires June 29, 2011. Rescinded: Filed Dec. 20, 2010.

*PUBLIC COST:* This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-2.075 Review and Appeals Procedure.** The Missouri Consolidated Health Care Plan is amending the rule purpose and all sections of this rule.

*PURPOSE:* This amendment changes the policy of the board of trustees in regard to review and appeals procedures for participation in, and coverage of services under, the Missouri Consolidated Health Care Plan.

*PURPOSE:* This rule establishes the policy of the board of trustees in regard to review and appeals procedures for participation in, and coverage of services under, the Missouri Consolidated Health Care Plan.

[(1) When any participant shall suffer any injury or sickness giving rise to claim under these rules, s/he shall have free choice of providers practicing legally in the location in which service is provided to the end that a provider/patient relationship shall be maintained. Reimbursement will be in accordance with the benefit provisions of the type of coverage chosen by the participant.

(2) The plan administrator, agent or claims administrator, upon receipt of a notice of request, shall furnish to the

employee the forms as are usually furnished for filing proofs of loss. If the forms are not furnished within thirty (30) days after the giving of such notice, the employee shall be deemed to have complied with the requirement as to proof of loss upon submitting, within the time fixed for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which request is made.

(3) Written proof of claims incurred should be furnished to the claims administrator as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the claims administrator before they are paid.

(4) In the case of medical benefits, the claims administrator will send written notice of any amount applied toward the deductible as well as any payments made. The claims administrator may also send a request for additional information or material to support the claim, along with reasons why this information is necessary.

(5) All members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the health plan contractor or claims administrator applicable to the member. Appeals to the health plan contractor or claims administrator must be made in writing within one hundred eighty (180) days of receiving the denial or notice which gave rights to the appeal. Only after these procedures have been exhausted may the member appeal directly to the Missouri Consolidated Health Care Plan to review the decision of the health plan contractor or claims administrator.

(A) Appeals to MCHCP shall be submitted in writing within forty-five (45) days of receiving the final decision from the member's health care plan contractor or claims administrator, specifically identifying the issue to be resolved. Administrative appeals shall be submitted in writing as soon as possible following written or verbal notice of an MCHCP staff denial of the member's administrative request. All appeals and administrative appeals shall be addressed to:

Attn: Appeal  
Board of Trustees  
Missouri Consolidated Health Care Plan  
PO Box 104355  
Jefferson City, MO 65110

(B) The board may, in its discretion, choose to conduct a hearing regarding a member's appeal. If the board decides a hearing is needed to render a decision, it may utilize a hearing officer or committee to conduct a fact-finding hearing and make proposed findings of fact and conclusions of law. In such cases—

1. The hearing will be scheduled by the MCHCP;
2. The parties to the hearing will be the insured and the applicable health plan or MCHCP staff in self-insured situations;
3. All parties shall be notified in writing of the date, time, and location of the hearing;
4. All parties shall have the right to appear at the hearing and submit written or oral evidence. The appealing party shall be responsible for all copy charges incurred by MCHCP in connection with any documentation that must be obtained through the MCHCP. These fees will be reimbursed should the party prevail in his/her appeal. They may cross-examine witnesses. They need not appear and may still offer written evidence. The strict rules of evidence shall not apply;

5. The party appealing to the board shall carry the burden of proof; and

6. The hearing officer shall propose findings of fact and conclusions of law, along with its recommendation, to the board. Copies of the summary, findings, conclusions, and recommendations shall be sent to all parties.

(C) The board may, but is not required to, review the transcript of the hearing and solicit additional evidence and argument. It will review the summary of evidence and the proposed findings of fact and conclusions of law and shall then issue its final decision on the matter.

1. All parties shall be given a written copy of the board's final decision.

2. All parties shall be notified that if they feel aggrieved by the final decision, they shall have the right to seek judicial review of the decision as provided by Missouri law.

(D) Administrative decisions made solely by MCHCP may be appealed directly to the board of trustees, by either a member or health plan contractor providing a fully-insured product.

1. All the provisions of this rule, where applicable, shall apply to these appeals.

2. The parties to such appeal shall be the appellant and the MCHCP shall be respondent.

3. The appellant, if aggrieved by the final decision of the board, shall have the right of appeal as stated in subsection (5)(C) herein.]

#### (1) Claims Submissions and Initial Benefit Determinations.

(A) Members shall use the claims and administration procedures established by the vendor administering the particular service for which coverage, authorization, or payment is sought.

(B) Medical and pharmacy service claims are divided into three (3) types: pre-service, post-service, and concurrent claims.

1. Pre-service claims are requests for approval that the plan or vendor requires a member to obtain before getting medical care or filling a prescription, such as prior authorization or a decision whether a treatment, procedure, or medication is medically necessary.

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than fifteen (15) days from the date the vendor receives the claim. The vendor may extend the time period up to an additional fifteen (15) days if, for reasons beyond the vendor's control, the decision cannot be made within the first fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

B. Urgent care claims are a special type of pre-service claim that require a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within seventy-two (72) hours. Written confirmation of the decision will be sent by the vendor as soon as possible thereafter.

2. Post-service claims are all other claims for services including claims after medical or pharmacy services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

A. Post-service claims must be decided within a reasonable period of time, but not later than thirty (30) days after the vendor receives the claim. If, because of reasons beyond the ven-

dor's control, more time is needed to review the claim, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

3. Concurrent claims are claims related to an ongoing course of previously-approved treatment. If the plan or vendor has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. The plan or vendor will notify a member in writing prior to reducing or ending a previously-approved course of treatment in sufficient time to allow the member or the member's provider to appeal and obtain a determination before the benefit is reduced or terminated.

(C) Claims incurred should be furnished to the vendor by the provider or the member as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the vendor before they are paid.

(D) If a member, or a provider or authorized representative on behalf of a member, submits a request for coverage or a claim for services that is denied in whole or in part, the member will receive an initial denial notice within the time frames described in this rule that will include the following information:

1. The reasons for the denial;

2. Reference to the plan provision, regulation, statute, clinical criteria, or guideline on which the denial was based with information as to how the member can obtain a copy of the provision, regulation, statute, clinical criteria, or guideline free of charge;

3. A description of any documentation or information that is necessary for the member to provide if documentation or information is missing and an explanation as to why the documentation or information is needed, if applicable; and

4. Information as to steps the member can take to submit an appeal of the denial.

#### (2) General Appeal Provisions.

(A) All individuals seeking review or appeal of a decision of the plan, plan administrator, claims administrator, or any vendor shall follow the procedures applicable to the type of decision appealed as set forth in this rule.

(B) All appeals must be submitted in writing to the appropriate reviewer as established in this rule by the member, the individual seeking review, or his/her authorized representative.

(C) Unless specifically provided otherwise in this rule, all appeals to the plan, plan administrator, claims administrator, or applicable vendor must be made, initiated in writing, within one hundred eighty (180) days of receiving the denial or notice which gave rights to the appeal.

#### (3) Appeal Process for Medical and Pharmacy Determinations.

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply.

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage once an individual has been covered under the plan, unless the individual, or a person seeking coverage on behalf of the individual, performs an act, practice, or omission that constitutes fraud, or unless such individual or person makes an intentional misrepresentation of material fact in connection with seeking coverage or any benefits under the plan.

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination.

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative.

4. External review. External review means a review of an adverse benefit determination (including a final internal adverse benefit determination) by the Missouri Department of Insurance, Financial Institutions and Professional Registration, Division of Consumer Affairs (DIFP) regarding covered medical and pharmacy benefits administered by plan vendors, UMR, Mercy Health Plans, or Express Scripts Inc., in accordance with state law and regulations promulgated by DIFP and made applicable to the plan by agreement and between the plan and DIFP pursuant to Technical Guidance from the U.S. Department of Health and Human Services dated September 23, 2010.

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law.

6. Final external review decision. A final external review decision means a determination rendered under the DIFP external review process at the conclusion of an external review.

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect;

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

C. The termination or discontinuance of coverage is effective retroactively at the request of the member in accordance with applicable provisions of this chapter regarding voluntary cancellation of coverage.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or

intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review by DIFP.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level appeals shall be responded to in writing to the member within sixty (60) days for post-service claims and within thirty

(30) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First level appeals must be submitted in writing to—

UMR Claims Appeal Unit  
PO Box 30546  
Salt Lake City, UT 84130-0546

(b) Second level appeals must be sent in writing to—

UMR Claims Appeal Unit  
PO Box 8086  
Wausau, WI 54402-8086

(c) Expedited appeals must be communicated by calling UMR telephone 1-866-868-7758 or by submitting a written fax to 1-866-912-8464, Attention: Appeals Unit.

(VI) For members with medical coverage through Mercy Health Plans—

(a) First and second level appeals must be submitted in writing to—

Mercy Health Plans  
Attn: Corporate Appeals  
14528 S. Outer 40 Road, Suite 300  
Chesterfield, MO 63017

(b) Expedited appeals must be communicated by calling Mercy Health Plans telephone 1-800-830-1918, ext. 2394 or by submitting a written fax to 1-314-214-3233, Attention: Corporate Appeals.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member claimant attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the claimant believes the claim should be paid, and any other written documentation to support the claimant's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts  
Clinical Appeals—MH3  
6625 West 78th Street, BL0390  
Bloomington, MN 55439  
or by fax to 1-877-852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and

will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(4) Except as otherwise expressly provided in this rule, appeals of adverse determinations made by MCHCP may be appealed to the board by fax or letter to the following address:

Attn: Appeal  
Board of Trustees  
Missouri Consolidated Health Care Plan  
PO Box 104355  
Jefferson City, MO 65110

[(6)](5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines:/.

(A) Newborns—If a member currently has coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within three (3) months of the child's date of birth.

(B) Agency error—MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office, the MCHCP, or plan offered by MCHCP that was no fault of the member.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year.

(D) Non-payment—MCHCP may allow one (1) reinstatement for terminations due to non-payment (per lifetime of account).

(E) Reinstatement before termination—MCHCP may reinstate coverage if request is received prior to end of current coverage.

(F) Termination dental and/or vision coverage—MCHCP may terminate dental and/or vision coverage if request is received prior to February 1 and if no claims have been made/paid for January.

(G) Proof of eligibility—MCHCP may approve late receipt of proof-of-eligibility documentation if MCHCP can verify that it took an unreasonable amount of time for the public entity (county or state) to provide subscriber with requested documentation.

(H) Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage.

(I) Loss of coverage notice—MCHCP may approve late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.

(J) *[Lifestyle Ladder] Wellness Program* participation—MCHCP may deny all appeals regarding continuation of participation in *[Lifestyle Ladder] the Wellness Program* due to failure of member's participation.

(K) Proof of open enrollment confirmation—MCHCP may approve appeals if subscriber is able to provide a confirmation sheet from open enrollment. However, such administrative appeals must be received by MCHCP on or before the last day of February.

(L) Substantiating evidence—MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period.

(M) New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the Code of State*

**Regulations.** *Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, terminated Jan. 20, 2011. Emergency amendment filed Jan. 10, 2011, effective Jan. 20, 2011, expires June 29, 2011. Amended: Filed Jan. 10, 2011.*

**PUBLIC COST:** *This proposed amendment will cost state agencies or political subdivisions one hundred twenty thousand dollars (\$120,000) in the aggregate.*

**PRIVATE COST:** *This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

**NOTICE TO SUBMIT COMMENTS:** *Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*



**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Name:</b>	<b>22 CSR 10-2.075 Review and Appeals Procedure</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan</b>	<b>\$120,000</b>

**III. WORKSHEET**

Estimated cost is the annual cost for all MCHCP external review costs for calendar year 2011.

**IV. ASSUMPTIONS**

- Vendors are not charging an additional fee for the internal member appeal process.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-2.090 Pharmacy Benefit Summary.** The Missouri Consolidated Health Care Plan is amending the rule purpose and sections (1), (6), and (7); deleting section (3) and renumbering accordingly; and adding sections (7) and (8).

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for the PPO 300, PPO 600, and Medicare Supplement Plans of the Missouri Consolidated Health Care Plan.*

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for the [HMO, Copay,] PPO 300, PPO 600, and Medicare Supplement Plans of the Missouri Consolidated Health Care Plan.*

(1) The pharmacy benefit provides coverage for prescription drugs **listed on the formulary**, as described in the following:

(A) Medications.

1. **Retail—Network:**

A. Generic: Eight-dollar (\$8) copayment for up to a thirty (30)-day supply for generic drug on the formulary;

B. *[Formulary brand]* **Brand:** Thirty-five-dollar (\$35) copayment for up to a thirty (30)-day supply for brand drug on the formulary;

*[C. Non-formulary: Fifty-five dollar (\$55) copayment for up to a thirty (30)-day supply for non-formulary drug;*

*D. Prescriptions filled with a formulary brand drug when there is a Food and Drug Administration (FDA)-approved generic will be subject to the generic copayment amount in addition to paying the difference between the cost of the generic and the formulary brand drug;]*

*[E/C. Mail order program—*

*(I) Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for [two and one-half (2 ½) regular copayments] a twenty-dollar (\$20) copayment for a generic drug on the formulary or a eighty-seven-dollar-and-fifty-cent (\$87.50) copayment for a brand drug on the formulary.*

*(II) Specialty drugs covered only through network mail order for up to thirty (30) days. Copayments[:—*

*(a) Generic: [six] eight dollars [and sixty-seven cents (\$6.67);] (\$8) for generic drug on the formulary list; and*

*[(b) Formulary brand: twenty-nine dollars and seventeen cents (\$29.17); and*

*(c) Non-formulary: forty-five dollars and eighty-three cents (\$45.83).]*

**(b) Brand: thirty-five dollars (\$35) for brand drug on the formulary.**

2. Non-network pharmacies—If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable copayment or coinsurance. All such claims must be filed within twelve (12) months of the incurred expense.

3. Retail prescription drugs—Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

*[(3) Retail and mail order coverage includes the following (except for specialty drugs):*

*(A) Diabetic supplies, including—*

*1. Insulin;*

*2. Syringes;*

*3. Test strips;*

*4. Lancets; and*

*5. Glucometers;*

*(B) Prescribed vitamins, excluding those vitamins that may be purchased over-the-counter;*

*(C) Prescribed self-injectables;*

*(D) Oral chemotherapy agents;*

*(E) Hematopoietic stimulants;*

*(F) Growth hormones with prior authorization;*

*(G) Infertility drugs—subject to fifty percent (50%) member coinsurance; and*

*(H) Tobacco cessation prescriptions—subject to formulary restrictions and limited to five hundred dollar (\$500) annual benefit.]*

*[(4)](3) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first step drug, the physician may request a prior authorization from the pharmacy plan administrator. If the prior authorization is approved, the member is responsible for the applicable copayment which may be higher than the first step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.*

*(A) First Step—*

*1. Uses primarily generic drugs;*

*2. Lowest applicable copayment is charged; and*

*3. First step drugs must be used before the plan will authorize payment for second step drugs.*

*(B) Second Step—*

*1. This step applies if the member's treatment plan requires a different medication after attempting the first step medication;*

*2. Uses primarily brand-name drugs; and*

*3. Typically, a higher copayment amount is applicable.*

*[(5)](4) Prior Authorization—Certain medications are subject to prior authorization. Network pharmacies will notify the member if prior authorization is required. The member or the pharmacy must contact the pharmacy plan administrator before payment will be approved.*

*[(6)](5) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy plan administrator. In order to file a claim, members must—*

*(A) Complete the claim form; and*

*(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions, except diabetic supplies. If attaching a receipt or label, the receipt or label shall include[—/]:*

*1. Pharmacy name and address;*

*2. Patient's name;*

*3. Price;*

*4. Date filled;*

*5. Drug name, strength, and national drug code (NDC);*

*6. Prescription number;*

- 7. Quantity; and
- 8. Days' supply.

**[(7)](6) Formulary**—The formulary *[does not change during a calendar year, unless]* **is updated on a semi-annual basis, or when—**

(A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; or

(B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit; *[and]* or

(C) A drug is determined to have a safety issue.

**(7) Limitation**—Prescription drugs not listed on the formulary are not a covered benefit except for prescription drugs that have been grandfathered for members who have taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011. If the participant purchased a brand-name drug that is grandfathered when there is a Food and Drug Administration (FDA)-approved generic drug, the participant shall pay the generic copayment plus the difference in the brand and generic cost of the drug. Grandfathered drugs include:

(A) Alzheimer's disease drugs;

(B) Antidepressants, including selective serotonin reuptake inhibitors (SSRIs) and selective serotonin and norepinephrine reuptake inhibitors (SNRIs);

(C) Anti-epileptics;

(D) Biologics for inflammatory conditions;

(E) Cancer drugs;

(F) Hemophilia drugs (Factor VIII and IX concentrates);

(G) Hepatitis drugs;

(H) Immunosuppressants (transplant anti-rejection agents);

(I) Insulin (basal);

(J) Low molecular weight heparins;

(K) Multiple sclerosis injectable drugs;

(L) Novel psychotropics (oral products and long-active injectables);

(M) Phosphate binders;

(N) Pulmonary hypertension drugs; and

(O) Somatostatin analogs.

**(8) Under the High Deductible Health Plan (HDHP)**, pharmacy benefits are subject to the applicable medical plan deductible and coinsurance.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Amended: Filed Dec. 22, 2010.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions \$64,037,434 in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities \$19,961,522 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 2**

<b>Rule Number and Name:</b>	<b>22 CSR 10-2.090 Pharmacy Benefit Summary</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan</b>	<b>\$ 64,037,434</b>

**III. WORKSHEET**

Estimated cost is the annual cost of the MCHCP providing pharmacy benefits to all state employees and eligible retirees and dependents who enrolled for coverage under an MCHCP plan for calendar year 2011.

**IV. ASSUMPTIONS**

- Total enrollment under MCHCP Plans as of November 17, 2010 (data used the CY2011 projection);
- Calendar year 2011 membership in all MCHCP Plans remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Actual costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.090 Pharmacy Benefit Summary</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>99,648 individuals enrolled in the MCHCP Plans for CY 2011</b>	<b>Individuals enrolled in the MCHCP Plans for CY 2011</b>	<b>\$ 19,961,522</b>

**III. WORKSHEET**

Estimated cost is the annual cost for all MCHCP subscribers' premium costs for pharmacy coverage for calendar year 2011. In addition, members will pay the following copayments based upon their individual utilization of covered benefits:

- \$8 copayment for up to a 30-day supply of generic medication obtained at retail pharmacy
- \$35 copayment for up to a 30-day supply of formulary medication obtained at retail pharmacy
- \$20 copayment for up to a 90-day supply of generic medication obtained at mail order pharmacy
- \$87.50 copayment for up to a 90-day supply of formulary medication obtained at mail order pharmacy

**IV. ASSUMPTIONS**

- Total enrollment in the MCHCP pharmacy plan as of November 17, 2010 (data used for the CY2011 projection);
- Calendar year 2011 membership in the MCHCP pharmacy plan remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED RULE**

**22 CSR 10-2.091 Wellness Program Coverage, Provisions, and Limitations**

*PURPOSE: This rule establishes the policy of the board of trustees in regards to the wellness program.*

(1) Eligibility—All non-Medicare primary active, retiree, terminated vested, long term disability (LTD), survivor, and Consolidated Omnibus Budget Reconciliation Act (COBRA) subscribers and their non-Medicare primary spouses enrolled in a Missouri Consolidated Health Care Plan (MCHCP) medical plan may participate in the wellness program. Each eligible member must participate separately.

(A) Members may begin participating on or after their eligibility date or during the open enrollment (OE) period.

(B) Spouses added mid-month due to marriage with a mid-month eligibility date will not be able to participate until the first of the month following their eligibility date.

(C) Members with a break in coverage within the same plan year may continue participation if they previously completed a Health Assessment (HA). Their HA will remain on record, along with any points previously accumulated.

(2) Limitations and Exclusions.

(A) Dependent children are not eligible to participate.

(B) Subscribers and/or covered spouses under the age of eighteen (18) are not eligible to participate.

(C) Members must have a Social Security number on file with MCHCP to be eligible to participate.

(D) When Medicare becomes a subscriber's primary insurance payer, the subscriber and participating spouse are no longer eligible to participate and will lose the wellness premium.

(E) When Medicare becomes a spouse's primary insurance payer, the spouse is no longer eligible to participate and will lose the wellness premium. The non-Medicare subscriber may continue to participate in the program.

(3) Participation. Members earn points through successful completion of activities as specified in the wellness program web portal through myMCHCP.

(A) The wellness program is voluntary.

(B) Members are responsible for enrolling, participating, and completing activities, as well as keeping track of their applicable deadlines and points.

(C) Each activity has different enrollment, participation, and completion criteria.

1. Some activities require use of the Internet and/or a unique email address.

2. The vendor will make all determinations regarding activity enrollment, participation, and completion.

3. The vendor will award all points upon completion of an activity.

4. Completion of activities outside of the wellness participation period may result in points being applied to the next wellness participation period.

5. Members with disabilities may request special accommodations in writing to the vendor regarding activity participation.

(D) The required HA must be completed annually before points begin accruing.

(E) Points are assigned by the vendor in the wellness participation period in which they are earned by the participating member.

(F) The wellness participation period is the time frame in which

activities must be completed in order to earn the wellness premium. The wellness participation periods are as follows: October 1–December 25; January 1–March 25; April 1–June 25; and July 1–September 25.

(G) The wellness coverage period is the time frame in which members receive the wellness premium for participation. The wellness coverage periods are as follows: January 1–March 31; April 1–June 30; July 1–September 30; and October 1–December 31.

(H) MCHCP and/or the vendor may audit participation information for accuracy. Misrepresentation or fraud could lead to termination from the wellness program, loss of the wellness premium, and/or prosecution.

(4) Wellness Premium. Members qualify for the wellness premium as follows:

(A) Points are the value of activities specified and awarded by the vendor upon successful activity completion;

(B) Points are accumulated in and can be monitored by the participating member from the wellness program web portal accessed through myMCHCP;

(C) Members reaching the minimum one hundred (100)-point threshold per wellness participation period will receive the wellness premium in the future wellness coverage period.

1. Members earning over one hundred (100) points in a given wellness participation period will receive the wellness premium in the future wellness coverage period, and all points over one hundred (100) will roll forward to be applied toward meeting the one hundred (100)-point threshold during the next wellness participation period.

2. Members not earning at least one hundred (100) points in a given wellness participation period will not receive the wellness premium for the future wellness coverage period, but the points earned totaling less than one hundred (100) will roll forward to be applied toward meeting the one hundred (100)-point threshold during the next wellness participation period.

3. A maximum of four hundred (400) points per wellness participation year is possible.

4. All earned points zero out at the end of the wellness participation year; and

(D) The wellness premium will be applied to subscriber paychecks or retiree benefit checks at the beginning of each wellness coverage period.

(5) Coordination of Programs. MCHCP and its wellness vendor may utilize participation data for purposes of offering additional programs in accordance with the wellness vendor's privacy policy.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2010, effective Jan. 1, 2011, expires June 29, 2011. Original rule filed Dec. 20, 2010.*

*PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED RULE**

**22 CSR 10-2.092 Dental Benefit Summary**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the dental benefit summary for members of the Missouri Consolidated Health Care Plan.*

- (1) Dental plan—The dental benefit provides coverage for—
  - (A) Coverage A—diagnostic and preventive services;
  - (B) Coverage B—basic and restorative services; and
  - (C) Coverage C—major services.
- (2) Procedures for Using the Dental Plan. A member may visit the dentist of his/her choice and select any dentist on a treatment-by-treatment basis. Members may go to a participating or non-participating network dentist. If a member goes to a non-participating network dentist, the dental plan will make payment directly to the member on the lesser of the dentist billed charge or the applicable maximum plan allowance.
- (3) Dental benefits, deductibles, and coinsurance include:

<b>DENTAL SERVICES</b>		
<b>Coverage A – Diagnostic &amp; Preventive</b>	<b>You Pay</b>	<b>Note</b>
Examinations Prophylaxes (teeth cleaning) Fluoride Bitewing X-rays Sealants	No deductible 0% coinsurance	Dental exams, X-rays, cleanings and fluoride treatment do not apply to the individual plan maximum
<b>Coverage B – Basic &amp; Restorative</b>	<b>You Pay</b>	<b>Note</b>
Emergency Palliative Treatment Space Maintainers All Other X-rays Minor Restorative Services (fillings) Simple Extractions	\$50/person deductible* 20% coinsurance	X-rays do not apply to the individual plan maximum
<b>Coverage C – Major Services</b>	<b>You Pay</b>	<b>Note</b>
Prosthetic Device Repair All Other Oral Surgery Periodontics Endodontics Prosthodontics (bridges, dentures) Major Restorative Services (crowns, inlays, onlays)	\$50/person deductible* 50% coinsurance	12-month waiting period for Coverage C services. The waiting period is waived with proof of 12-month continuous dental coverage for major services immediately prior to the effective date of coverage in MCHCP's dental plan
<b>Coverage is limited to \$1,000 per person per calendar year.</b> <b>*Coinsurance amounts apply after the \$50 individual deductible is met under either Coverage B or C, or combined.</b>		

(4) Alternative Treatment. If alternative treatment plans are available, this dental plan will be liable for the least costly, professionally satisfactory course of treatment. This includes, but is not limited to, services such as composite resin fillings on molar teeth, in which case the benefits are based on the cost of the amalgam (silver) filling. This also includes fixed bridges, in which case the benefits will be based on the cost of a removable partial denture.

(5) Transferring Care. If participant receives care from more than one (1) dentist or service provider for the same procedure, benefits will not exceed what would have been paid for one (1) dentist for that procedure (including, but not limited to, prosthetic devices and root canal therapy).

(6) Claim Pre-Determination. If the care member needs costs less than two hundred dollars (\$200) or is emergency care, member's dentist will proceed with treatment at member's option. If the cost estimate is more than two hundred dollars (\$200) and is not emergency care, member's dentist will determine what treatment member needs and could submit a treatment plan to dental plan for a pre-determination of benefits. This estimate will enable the member to determine in advance how much of the cost will be paid by his/her dental coverage and how much s/he will be responsible for paying.

(7) Claim Filing Deadline. Member's claims must be filed by the end

of the calendar year after the year in which services were rendered. The dental plan is not obligated to pay claims submitted after this period. If a claim is denied due to a participating dentist's failure to make timely submission, participant will not be liable to such dentist for the amount that would have been payable by the dental plan, provided that member advised the dentist of participant's eligibility for benefits at the time of treatment.

**AUTHORITY:** section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Original rule filed Dec. 22, 2010.

**PUBLIC COST:** This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

**PRIVATE COST:** This proposed rule will cost private entities \$13,746,852 in the aggregate.

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.



**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 – Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.092 Dental Benefit Summary</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>30,665 individuals enrolled in MCHCP Dental Plan for CY 2011</b>	<b>Individuals enrolled in the MCHCP Dental Plan for CY 2011</b>	<b>\$13,746,852</b>

**III. WORKSHEET**

Estimated cost is the annual cost for MCHCP subscribers' premium costs for dental coverage for calendar year 2011. Dental coverage is limited to a \$1,000 per person calendar year benefit. In addition, members will pay the following deductible and coinsurance based upon their individual utilization of covered benefits:

- \$50 annual deductible per person and 20% coinsurance for Coverage B – Basic & Restorative
  - Coinsurance amounts apply after the \$50 individual deductible is met under either Coverage B or C or combined
- \$50 annual deductible per person and 50% coinsurance for Coverage C – Major Services
  - Coinsurance amounts apply after the \$50 individual deductible is met under either Coverage B or C or combined

**IV. ASSUMPTIONS**

- Total enrollment in the MCHCP dental plan as of December 8, 2010 (data used for the CY2011 projection);
- Calendar year 2011 membership in the MCHCP dental plan remains relatively stable;

- Calendar year 2011 rates based on projections of fully-insured premiums as developed by Delta Dental;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED RULE**

**22 CSR 10-2.093 Vision Benefit Summary**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the vision benefit summary for members of the Missouri Consolidated Health Care Plan.*

(1) Vision Plan. The vision benefit provides coverage of refractive care exams, eyeglass lenses and frames, contact lenses, and corrective laser surgeries.

(2) Vision benefits and copayments include:

<b>VISION SERVICES</b>		
<b>BENEFITS</b>	<b>NETWORK</b>	<b>NON-NETWORK</b>
<b>Exams – once every 12 months</b>		
<b>Vision Exam</b>	\$10 copayment	Reimbursed up to \$36
<b>Lenses – once every 12 months – one \$25 copayment for lenses and frames when purchased together</b>		
<b>Single vision lenses (per pair)</b>	\$25 copayment	Reimbursed up to \$28
<b>Bifocal lenses (per pair)</b>	\$25 copayment	Reimbursed up to \$45
<b>Trifocal lenses (per pair)</b>	\$25 copayment	Reimbursed up to \$56
<b>Lenticular lenses (per pair)</b>	\$25 copayment	Reimbursed up to \$80
<b>Polycarbonate lenses (per pair)</b> Applies to dependent children only	\$25 copayment	Not covered
<b>Frames – once every 24 months – one \$25 copayment for lenses and frames when purchased together</b>		
<b>Frames</b>	<b>\$25 copayment</b> <b>Up to \$120 plus 20% discount on any out-of-pocket costs</b>	<b>Reimbursed up to \$45</b>
<b>Contact Lenses – once every 12 months in place of eye glass lenses</b>		
<b>Elective</b> If member prefers contacts to glasses	\$10 copayment for exam  Up to \$125 for contact lenses and contact lens exam (fitting and evaluation)  15% discount on the cost of contact lens exam (fitting and evaluation)	Reimbursed up to \$36 for exam  Contact lenses, evaluation, design and fitting reimbursed up to \$105
<b>Necessary</b> If medically necessary with prior approval from VSP	\$10 copayment for exam  Additional costs covered at 100%	Reimbursed up to \$36 for exam  Contact lenses, evaluation, design and fitting reimbursed up to \$210
<b>Corrective Laser Surgery – contact your provider, or contact VSP at 888-354-4434 for more information</b>		

<b>PRK</b>	Maximum amount you pay: \$1,500 per eye	Not covered
<b>LASIK</b>	Maximum amount you pay: \$1,800 per eye	Not covered
<b>Custom LASIK</b>	Maximum amount you pay: \$2,300 per eye	Not covered
<b>Other</b>		
<b>Optional Items (cosmetic extras)</b>	Not covered	Not covered

(3) Value-Added Discount Program. A member can receive a twenty-percent (20%) discount on additional glasses and sunglasses, including lens options from any network provider, within twelve (12) months of participant's last eye exam.

(4) Soft Contact Lenses. A member who wears soft contact lenses will qualify for a special contact lens program. The program covers—

(A) A contact lens exam;

(B) Six (6)-month supply of contacts from the specific list of contact lens products and manufacturers; and

(C) Two (2) follow-up visits.

(D) A member who requires premium services when being fitted for contact lenses will not qualify for the contact lens care program. The member's provider will determine if the member qualifies for a standard fit or a premium fit based on the guidelines of—

1. Standard fit contact lens patients—

A. Typically the member does not require additional time for care, training, or problem solving; and

B. Typically the member can be successfully fitted in up to two (2) follow-up visits; and

2. Premium fit contact lens patients—

A. Typically the member will require additional time for care, training, or problem solving; and

B. Typically the member cannot be successfully fitted in up to two (2) follow-up visits.

(E) The member will be responsible for the cost above the allowed network or non-network contact lens benefit. Contact lens care program products, manufacturers, replacement fees, and refit fees are as follows:

Tier One: Spherical				
Product	Manufacturer	Boxes Covered	Replacement Wearers	Refit Wearers
ACUVUE	Vistakon	4	\$130	\$170
ACUVUE 2	Vistakon	4		
AIR OPTIX AQUA	CIBA Vision	2		
Biofinity	CooperVision	2		
Biomedics 55 Premier	CooperVision	4		
Biomedics 55 UV	CooperVision	4		
Biomedics XC	CooperVision	4		
Focus Monthly Visitint (Focus Visitint)	CIBA Vision	2		
Frequency 38	CooperVision	2		
Frequency 55 Aspheric	CooperVision	2		
Frequency 55 Sphere	CooperVision	2		
FreshLook Handling Tint	CIBA Vision	4		
O2OPTIX	CIBA Vision	2		
Proclear Sphere (Compatibles)	CooperVision	2		
PureVision	Bausch & Lomb	2		
SofLens 39 (Optima FW, Seequence II)	Bausch & Lomb	4		
Vertex Sphere (Encore Sphere)	CooperVision	4		

Tier Two: Spherical				
Product	Manufacturer	Initial Supply Boxes	Replacement Wearers	Refit Wearers
ACUVUE ADVANCE	Vistakon	4	\$160	\$190
ACUVUE OASYS with HYDRACLEAR PLUS	Vistakon	4		
AIR OPTIX NIGHT & DAY AQUA	CIBA Vision	2		
Avaira	CooperVision	4		
Biomedics 38	CooperVision	4		
Extreme H <sub>2</sub> O 59% - Thin	Hydrogel	4		
Extreme H <sub>2</sub> O 59% - Xtra	Hydrogel	4		
Extreme H <sub>2</sub> O 54%	Hydrogel	4		
Focus 1-2 Week Visitint (NewVues Visitint)	CIBA Vision	4		
PRECISION UV	CIBA Vision	4		

<b>Tier Three: Specialty Lenses</b>				
<b>Product</b>	<b>Manufacturer</b>	<b>Initial Supply Boxes</b>	<b>Replacement Wearers</b>	<b>Refit Wearers</b>
<b>ACUVUE ADVANCE <i>for ASTIGMATISM</i></b>	<b>Vistakon</b>	<b>4</b>	<b>\$180</b>	<b>\$210</b>
<b>ACUVUE OASYS <i>for ASTIGMATISM</i></b>	<b>Vistakon</b>	<b>4</b>		
<b>AIR OPTIX <i>for ASTIGMATISM</i></b>	<b>CIBA Vision</b>	<b>2</b>		
<b>Biofinity Toric</b>	<b>CooperVision</b>	<b>2</b>		
<b>Focus Monthly Toric Visiint (Focus Toric)</b>	<b>CIBA Vision</b>	<b>2</b>		
<b>Frequency 55 Multifocal</b>	<b>CooperVision</b>	<b>2</b>		
<b>Frequency 55 Toric</b>	<b>CooperVision</b>	<b>2</b>		
<b>Proclear EP Multifocal</b>	<b>CooperVision</b>	<b>4</b>		
<b>PureVision Multifocal</b>	<b>Bausch &amp; Lomb</b>	<b>2</b>		
<b>PureVision Toric</b>	<b>Bausch &amp; Lomb</b>	<b>2</b>		
<b>SofLens Toric</b>	<b>Bausch &amp; Lomb</b>	<b>4</b>		

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Original rule filed Dec. 22, 2010.*

*PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed rule will cost private entities \$2,584,704 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 – Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.093 Vision Benefit Summary</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>25,808 individuals enrolled in MCHCP Vision Plan for CY 2011</b>	<b>Individuals enrolled in the MCHCP Vision Plan for CY 2011</b>	<b>\$2,584,704</b>

**III. WORKSHEET**

Estimated cost is the annual cost for MCHCP subscribers' premium costs for the vision plan for calendar year 2011. In addition, member payment will depend upon their individual utilization of covered benefits and following the payment schedule:

**In- network**

- \$10 copayment for vision exam
- \$25 copayment for single vision, bifocal, trifocal, lenticular and polycarbonate lenses
- \$25 copayment for frames
- \$25 copayment for lenses and frames when purchased together
- \$25 copayment and reimbursement up to \$120 for frames
- \$10 copayment for vision exam with reimbursed up to \$125 for contact lenses and contact lens exam for elective lenses
- \$10 copayment for vision exam with additional costs covered at 100% for medically necessary contact lenses
- \$1,500 maximum amount member pays for PRK Corrective Laser Surgery per eye
- \$1,800 maximum amount member pays for LASIK Corrective Laser Surgery per eye



- \$2,300 maximum amount member pays for Custom LASIK Corrective Laser Surgery per eye

**Non Network**

- Reimbursed up to \$36 for vision exam
- Reimbursed up to \$28 for single vision lenses
- Reimbursed up to \$45 for bifocal lenses
- Reimbursed up to \$56 for trifocal lenses
- Reimbursed up to \$80 for lenticular lenses
- Reimbursed up to \$45 for frames
- Reimbursed up to \$36 for vision exam and elective contact lenses, evaluation, design and fitting reimbursed up to \$105
- Reimbursed up to \$36 for vision exam and medical necessary contact lenses, evaluation, design and fitting reimbursed up to \$210

**IV. ASSUMPTIONS**

- Total enrollment in the MCHCP vision plan as of December 8, 2010 (data used for the CY2011 projection);
- Calendar year 2011 membership in the MCHCP vision plan remains relatively stable;
- Calendar year 2011 rates based on projections of fully-insured premiums as developed by Vision Service Plan;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-3.010 Definitions.** The Missouri Consolidated Health Care Plan is deleting sections (3), (26), (33), (37), (44), (49), (53), (54), (68), (70), (77), (91)–(93), (95), (98), (114), (124), and (128); amending sections (5), (7), (10), (13), (17), (22)–(24), (29), (30), (32), (34), (36), (39), (41)–(43), (46), (48), (52), (64), (69), (71), (72), (74), (78), (81), (82), (84), (85)–(88), (90), (94), (96), (99), (101), (103)–(105), (109), (111), (113), (115), (116), (121), (126), and (131); adding new sections (2), (7), (8), (14), (15), (29), (31), (33), (40), (41), (44), (52), (55), (68), (69), (72), (95), (125), and (130); and renumbering as necessary.

*PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan relative to public entities and public entity members.*

*PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.*

**(2) Activities of daily living.** Bathing, dressing, toileting, and associated personal hygiene; transferring (being moved in and out of a bed, chair, wheelchair, tub, or shower); mobility, eating (getting nourishment into the body by any means other than intravenous), and continence (voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

**[(2)](3) Administrative appeal.** A written request submitted by or on behalf of a member involving plan-related administrative issues such as eligibility, effective dates of coverage, plan changes, etc.

**[(3) Administrative guidelines.** Instructive interpretation of the plan document developed for administration of the plan. The administrative guidelines may be changed upon approval of the executive director or his/her designee. Benefits provided shall be those in effect at the time services are rendered.]

**(5) Allowable expense.** Charges for services rendered or supplies furnished by a health plan that would qualify as covered expenses and for which the program pays in whole or in part, subject to any deductible[,], and coinsurance[,], or table of allowance included in the program] amounts.

**(7) Applied behavior analysis.** The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior.

**(8) Assignment.** When a doctor agrees to accept Medicare's fee as full payment.

**[(7)](9) Benefit period.** The three hundred sixty-five (365) days immediately [following the first date of like services] after the first date of the services to treat a given condition.

**[(8)](10) Benefits.** Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator.

**[(9)](11) Birthday rule.** If both parents have medical coverage, the primary plan for dependent children is the plan of the parent whose birthday occurs first in the calendar year. If birthdays occur on the same day, the parent's coverage that has been in effect longest is primary.

**[(10)](12) Board.** The board of trustees of the Missouri Consolidated Health Care Plan (MCHCP).

**[(11)](13) Calendar year.** The period of time from January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All annual deductibles and benefit maximums accumulate during the calendar year.

**(14) Cancellation of coverage.** The voluntary cancellation of medical, dental, or vision coverage per a subscriber's request.

**(15) Case management.** A coordinated set of activities conducted for individual patient management of serious or complicated health conditions.

**[(12)](16) Chiropractic services.** The examination, diagnosis, adjustment, manipulation, and treatment of malpositioned articulations and structures of the body, directed toward restoring and maintaining the normal neuromuscular and musculoskeletal function and health.

**[(13)](17) Claims administrator.** An organization or group responsible for the processing of claims and associated services for [the plan's self-insured benefit programs, including but not limited to the preferred provider organization (PPO) (also known as the copay plan) and health maintenance organization (HMO) type plans] a health plan.

**[(14)](18) Coinsurance.** The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.

**[(15)](19) Comprehensive major medical.** A plan that provides for cost sharing to be applied to all covered expenses, such as deductible or coinsurance.

**[(16)](20) Congenital defect.** Existing or dating from birth. Acquired through development while in the uterus.

**[(17)](21) Convenient care clinics (CCCs).** Health care clinics located in retail stores, supermarkets, and pharmacies that treat routine family illnesses and provide preventive health care services. They are sometimes referred to as "retail-based clinics" or "walk-in medical clinics." [CCCs are usually staffed by nurse practitioners or physician assistants. Some CCCs, however, are staffed by physicians.]

**[(18)](22) Coordination of benefits.** Communication, adjustment, and reconciliation procedures between multiple benefit plans covering the same member for purposes of covering services and expenses relating to plan benefits.

**[(19) Copay plan.** A set of benefits similar to a health maintenance organization option.]

**[(20)](23) Copayment.** A set dollar amount that the covered individual must pay for specific services.

**[(21)](24) Cosmetic surgery.** A procedure performed primarily for psychological purposes or to preserve or improve appearance rather

than restore the anatomy and/or function of the body which are lost or impaired due to illness or injury.

**[(22)](25)** Covered benefits and charges. *[A schedule of covered services and charges payable under the plan. The benefits covered under each type of plan are outlined in the applicable rule in this chapter.]* Covered benefits are a schedule of health care services payable under the plan. Covered charges are the cost for medical services eligible for consideration under the plan.

**[(23)](26)** Custodial care. Services and supplies furnished primarily to assist an individual to meet the activities of daily living. *Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services* that can be provided by persons without the training of a health care provider or that do not entail and require the continuing attention of trained medical or paramedical personnel.

**[(24)](27)** Date of service. Date medical services are received *[or performed]*.

**[(25)](28)** Deductible. The amount of expense the member must pay before the plan begins to pay for covered services and supplies. This amount is not reimbursable by the plan.

**[(26)]** *Dependent-only participation. Participation of certain survivors of subscribers. Dependent participation may be further defined to include the deceased subscriber's:*

- (A) Spouse only;*
- (B) Child(ren) only; or*
- (C) Spouse and child(ren).]*

**(29) Dependent child.** Any child under the age of twenty-six (26) that is a natural child, legally adopted or placed for adoption child, or a child with one (1) of the following legal relationships with the member, so long as such legal relationship remains in effect:

- (A) Stepchild;**
- (B) Foster child** for whom the employee is responsible for health care;
- (C) Grandchild** for whom the employee has legal guardianship or legal custody and is responsible for providing health care; and
- (D) Other child** for whom the employee is court-ordered legal guardian responsible for providing health care.

1. Except for a disabled child as described in 22 CSR 10-2.010(88), a dependent child is eligible from his/her eligibility date to the end of the month he/she attains age twenty-six (26) (see paragraph 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child beyond age twenty-six (26)).

**[(27)](30)** Dependents. The lawful spouse of the employee, the employee's unemancipated child(ren), and certain survivors of employees, as provided in the plan document and these rules, for whom application has been made and has been accepted for participation in the plan.

**(31) Diagnostic.** Describes a procedure to determine whether a person has a particular illness.

**[(28)](32)** Diagnostic charges. The Usual, Customary, and Reasonable (UCR) charges or the network discounted rate (NDR) for x-ray or laboratory examinations made or ordered by a physician in order to detect a medical condition.

**(33) Disease management.** A program offered to non-Medicare members to help manage certain chronic diseases.

**[(29)](34)** Disposable supplies. *[Medical s/Supplies* that do not withstand prolonged use and are periodically replaced. Includes, but

not limited to, colostomy and ureterostomy bags.

**[(30)](35)** Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:

- (A) Doctor of medicine;
- (B) Doctor of osteopathy;
- (C) Podiatrist;
- (D) Optometrist;
- (E) Chiropractor;
- (F) Psychiatrist;**
- [(F)](G)** Psychologist;
- [(G)](H)** Doctor of **dental medicine, including** dental surgery; *[or]*

**(I) Doctor of dentistry; or**

**[(H)](J)** Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

**[(31)](36)** Durable medical equipment (DME). Equipment able to withstand repeated use for the therapeutic treatment of an active illness or injury. Such equipment is not covered under the plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.

**[(32)](37)** Eligibility date. *[Refer to] As described in 22 CSR 10-3.020. [for effective date provisions. Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of eligibility as determined by the employer.]*

**[(33)]** *Emancipated child(ren). A child(ren) who is—*

- (A) Employed on a full-time basis;*
- (B) Eligible for group health benefits in his/her own behalf;*
- (C) Maintaining a residence separate from his/her parents or guardian—except for full-time students in an accredited school or institution of higher learning; or*
- (D) Married.]*

**[(34)](38)** Emergency medical condition. *[Any medical condition leading a prudent layperson to seek immediate medical attention. This normally means the sudden onset of a health condition that manifests itself by acute symptoms and severity (including severe pain). Examples of medical emergencies include, but are not limited to:] A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—*

- (A) Conditions placing a person's health in significant jeopardy;*
- (B) Serious impairment to a bodily function;*
- (C) Serious dysfunction of any bodily organ or part;*
- (D) Inadequately controlled pain; or*
- (E) Situations when the health of a pregnant woman or her unborn child are threatened.*

**[(35)](39)** Emergency room. The section of a hospital equipped to furnish emergency care to prevent the death or serious impairment of the covered person.

**(40) Emergency Services.** With respect to an emergency medical condition—

**(A)** A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department to evaluate such emergency medical condition; and

**(B)** Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities

available at the hospital, as are required to stabilize the patient. The term “to stabilize” means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility.

**(41) Employee.** A person employed by a participating public entity and present and future retirees from the participating public entity who meet the eligibility requirements as prescribed by the participating public entity.

*[(36)](42) Employee and dependent participation.* Participation of an employee and the employee’s eligible dependents. Any individual eligible for participation as an employee is not eligible as a dependent except as noted in 22 CSR 10-3.030(1)(A)7. *[Dependent participation may be further defined to include the participating employee’s:*

- (A) Spouse only;*
- (B) Child(ren) only; or*
- (C) Spouse and child(ren).]*

*[(37) Employees.* Employees of the participating public entity and present and future retirees from the participating public entity who meet the eligibility requirements as prescribed by the participating public entity.]

*[(38)](43) Employer.* The public entity that employs the eligible employee as defined above.

**(44) Essential benefits.** The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

- (A) Ambulatory patient services—office visits, urgent care, outpatient diagnostic procedures, outpatient surgery, and outpatient hospice;**
- (B) Emergency services—ambulance services and emergency room services;**
- (C) Hospitalization—inpatient hospital benefits, inpatient surgery, transplants, and inpatient hospice;**
- (D) Maternity and newborn care—maternity coverage and newborn screenings;**
- (E) Mental health and substance abuse disorder services, including behavioral health treatment—inpatient and outpatient and mental health/chemical dependency office visits;**
- (F) Prescription drugs;**
- (G) Rehabilitative and habilitative services and devices—durable medical equipment; cardiac and pulmonary rehabilitation; outpatient physical, speech, and occupational therapy; and home health care/palliative services;**
- (H) Laboratory services—lab and x-ray;**
- (I) Preventive and wellness services and chronic disease management; and**
- (J) Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, immunizations, preventive services, and newborn screenings.**

*[(39)](45) Executive director.* The chief executive officer of the Missouri Consolidated Health Care Plan (MCHCP) who shall have charge of the offices, records, and employees of the plan, subject to the direction of the board of trustees.

*[(40)](46) Experimental/Investigational/Unproven.* A treatment, procedure, device, or drug that meets any of the criteria listed below is considered experimental/investigational/unproven and is not eligible for coverage under the plan. Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.

Experimental/investigational/unproven is defined as a treatment, procedure, device, or drug that the plan administrator determines, in the exercise of its discretion:/—

(A) Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law;

(B) Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or

(C) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficiency as compared with the standard means of treatment or diagnosis.

*[(41)](47) First eligible.* The first thirty-one (31)-day period after a member’s employment date in which the member and his/her dependents may enroll in an MCHCP plan. As a member acquires new dependents, his/her first eligible period is the first thirty-one (31) days from the date *[the dependent meets the eligibility requirements for coverage under the plan]* of the lift event.

*[(42)](48) Formulary.* A list of drugs covered by the pharmacy *[program claims administrator]* benefit manager and as allowed by the plan administrator.

*[(43)](49) Generic drug.* *[A chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.]* There are two (2) types of generic drugs, a therapeutically equivalent generic and a chemically equivalent generic, as defined below.

(A) Therapeutically equivalent generic drugs are drugs with active ingredients that are similar at the clinical level.

(B) Chemically equivalent generic drugs are drugs with active ingredients that are identical at the molecular level. The brand-name drug lost its patent and the generic is available for the exact drug.

*[(44) Grievance.* A written complaint submitted by or on behalf of a member regarding either:

(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or

(B) Claims payment, handling, or reimbursement for health care services.]

*[(45)](50) Group health plan.* A plan maintained by an employer or an employee organization to provide medical care or other health services, directly or indirectly, to employees, former employees, and their families, including but not limited to Medicare and Medicaid plans.

*[(46)](51) Handbook.* The summary plan document prepared for members explaining the terms, conditions, and all material aspects of the plan and benefits offered under the plan, a copy of which is incorporated by reference into this rule. The full text of material incorporated by reference *[will be made]* is available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, 2010 State Member Handbook *[(January 1, 2010) January 10, 2011]* or online at [www.mchcp.org](http://www.mchcp.org). It does not include any later amendments or additions.

**(52) Health care benefit.** Coverage under the plan to include medical, dental, vision, and pharmacy.

*[(47)](53) Health savings account (HSA).* A tax-advantaged savings

account that may be used to pay current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA. HSA funds can be used to help pay the deductible, coinsurance, and any qualified medical expenses not covered by the health plan.

**[(48)](54) High Deductible Health Plan (HDHP).** A health plan with higher deductibles than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

**[(49)]** *Home health agency.* An agency certified by Medicare and the Missouri Department of Health and Senior Services, or any other state's licensing or certifying body, to provide health care services to persons in their homes.]

**(55) Home health care. Skilled nursing services and other therapeutic services to persons in their homes provided by an agency certified by Medicare and licensed pursuant to state or local law.**

**[(50)](56) Hospice.** A public agency, private organization, or a subdivision of either that primarily engages in providing care to terminally ill individuals, meets the conditions of participation for hospices, holds a valid Medicare provider agreement, and is licensed pursuant to state law.

**[(51)](57) Hospice facility.** A public or private organization, certified by Medicare and any other state's licensing or certifying body, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one (1) physician, one (1) registered nurse, one (1) social worker, one (1) volunteer, and a volunteer program. A hospice facility is not a facility, or part thereof, which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.

**[(52)](58) Hospital.**

(A) An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic, and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24)-hour-a-day nursing service by a registered nurse (RN) on duty or call.

(B) An institution not meeting all the requirements of **[(52)](A)** subsection **(58)(A)** above, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

(C) An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).

(D) A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.

(E) A residential alcoholism, chemical dependency, or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction.

(F) In no event shall the term hospital include a skilled nursing facility or any institution, or part thereof, which is used primarily as a skilled nursing facility, nursing home, rest home, or facility for the aged.

**[(53)]** *Hospital copayment.* Set dollar amount a subscriber must pay for each hospital admission.]

**[(54)]** *Hospital room charges.* The hospital's most common charge for semi-private accommodations, or the most common charge for a private room if that is the only type of

*room available or if a private room has been recommended by a physician and approved by the claims administrator or the plan administrator.]*

**[(55)](59) Illness.** Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered as any other illness.

**[(56)](60) Incident.** A definite and separate occurrence of a condition.

**[(57)](61) Infertility.** Any medical condition causing the inability or diminished ability to reproduce.

**[(58)](62) Infertility services.** Services including confinement, treatment, or other services related to the restoration of fertility or the promotion of conception.

**[(59)](63) Injury.** A condition that results independently of an illness and all other causes and is a result of an external force or accident.

**[(60)](64) Inpatient.** Confined to a registered bed. Patient in hospital, skilled nursing facility, hospice facility, or free-standing chemical dependency treatment center.

**[(61)]** *Legend.* Any drug that requires a prescription from either a physician or a practitioner, under either federal or applicable state law, in order to be dispensed.]

**[(62)](65) Life events.** Events occurring in an individual's life to include: marriage, birth, adoption, or placement of children.

**[(63)](66) Lifetime.** The period of time a member or the member's eligible dependents participate in the plan.

**[(64)](67) Lifetime maximum.** The *[maximum]* amount payable by a medical plan during a covered member's life **for specific non-essential benefits.**

**(68) MCHCPid.** An individual MCHCP member identifier used for member verification and validation.

**(69) myMCHCP.** A secure MCHCP member website that includes coverage selection, level of coverage, an option to change a mailing address, an option to add or change an email address, an option to request an MCHCPid card, and access to other pertinent websites.

**[(65)](70) Medical benefits coverage.** Services that are received from providers recognized by the plan and are covered benefits under the plan.

**[(66)](71) Medically necessary.** Treatments, procedures, services, or supplies that the plan administrator determines, in the exercise of its discretion/:]—

(A) Are expected to be of clear clinical benefit to the patient;

(B) Are appropriate for the care and treatment of the injury or illness in question; and

(C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.

**(72) Medicare allowed amount.** The fee Medicare sets as reasonable for a covered medical service. This is the amount a provider

is paid by the member and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or provider.

[(67)](73) Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

[(68)](74) Morbid obesity. Body Mass Index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions approved by the plan administrator based on clinical review.]

[(69)](74) Network provider. A physician, hospital, pharmacy, [etc.,] or other health provider that is contracted with the plan or its designee.

[(70)](75) Non-embedded deductible. The family deductible that must be met before claim payments begin, applicable when two (2) or more family members are covered in the HDHP.]

[(71)](75) Non-formulary. A drug not contained on the pharmacy [program's formulary] benefit manager's list [but may be covered under the terms and conditions of the plan] of covered drugs.

[(72)](76) Non-network provider or non-participating provider. Any physician, hospital, pharmacy, [etc.,] or other health provider that does not have a contract with the plan or its designee.

[(73)](77) Nurse. A registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule.

[(74)](78) Nursing home. An institution operated, pursuant to law, primarily for custodial care or for patients [convalescing] recovering from illness or injury, under the supervision of a physician or registered nurse and having twenty-four (24)-hour nursing care. Also, an institution meeting the preceding criteria which is established for the treatment of sick and injured persons through spiritual means and is operated under the authority of organizations [which] that are recognized under Medicare.

[(75)](79) Open enrollment period. A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year.

[(76)](80) Out-of-area. Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria.

[(77)](81) Out-of-network. Providers that do not participate in the member's health or pharmacy plan.]

[(78)](81) Out-of-pocket maximum. [The maximum amount the member must pay before the plan begins paying one hundred percent (100%) of covered charges for the remainder of the calendar year.] The annual limit on the amount a member must pay for covered services. Above this limit, the medical plan pays one hundred percent (100%) for covered services for the rest of the plan year.

[(79)](82) Outpatient. Treatment either outside a hospital setting or at a hospital when room and board charges are not incurred.

[(80)](83) Outpatient observation stay. Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services are less than twenty-four (24) hours. Members may receive observation services in the emergency room, an observation unit, the intensive care unit, or a regular floor.

[(81)](84) Palliative services. Care provided by a team approach that improves the quality of life for patients and their families facing problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and [impeccable] assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

[(82)](85) Partial hospitalization. A distinct and organized intensive ambulatory treatment service, less than twenty-four (24)-hour daily care specifically designed for the diagnosis and active treatment of a mental/nervous disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.

(A) Partial hospitalization programs must provide diagnostic services; services of social workers; [psychiatric] nurses and staff trained to work with psychiatric patients; individual, group, and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions [for therapeutic purposes].

(B) The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a physician.

[(83)](86) Participant. Any employee or dependent accepted for membership in the plan.

[(84)](87) Pharmacy benefit manager (PBM). [Acts as a link between the parties involved in the delivery of prescription drugs to health plan members.] The PBM designs, implements, and manages the overall drug benefit of the plan and processes claims payments.

[(85)](88) Physically or mentally disabled. [The inability of a person] A person's inability to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition.

[(86)](89) Physician/Doctor. A licensed practitioner of the healing arts, acting within the scope of his/her practice, as licensed under section 334.021, RSMo.

[(87)](90) Plan. The program of health care benefits established by the board of trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

[(88)](91) Plan administrator. The board of trustees of the Missouri Consolidated Health Care Plan. As such, the board, which is the sole fiduciary of the plan[,], The board has all discretionary authority to interpret its provisions and to control the operation and administration of the plan[,], and whose decisions are final and binding on all parties.

[(89)](92) Plan document. The statement of the terms and conditions of the plan as promulgated by the plan administrator in this chapter.

[(90)](93) Plan year. [Same as] The calendar year beginning January 1 through December 31. This is the period during which

**the total amount of annual benefits is calculated. All deductibles and benefit maximums accumulate during the calendar year.**

*[(91)]* **Pre-admission testing.** *X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission.]*

*[(92)]* **Pre-certification.** *Also known as pre-admission certification, pre-admission review, and pre-certification. The process of obtaining certification or authorization from the plan for routine hospital admissions and surgical or diagnostic procedures (inpatient or outpatient).]*

*[(93)]* **Pre-existing condition.** *A condition for which a member has incurred medical expenses or received treatment prior to the effective date of coverage.]*

(94) **Preferred provider organization (PPO).** An arrangement with providers whereby discounted rates are given to plan members. *[of the plan who, in turn, are offered a financial incentive to use these providers]* Benefits are paid at a higher level when network providers are used.

*[(95)]* **Prevailing fee.** *The fee charged by the majority of dentists.]*

**(95) Preventive service.** A procedure intended for avoidance or early detection of an illness.

(96) **Primary care physician (PCP).** A physician (usually an internist, family/general practitioner, or pediatrician) who has contracted with *[and been approved by]* a medical plan.

(97) **Prior authorization.** A cost control procedure that requires the service or medication to be approved in advance by the doctor and/or the plan. Without prior authorization, the plan may not pay for the test, drug, or service. Also known as pre-authorization or pre-notification.

*[(98)]* **Prior plan.** *The terms and conditions of a plan in effect for the period preceding coverage in the plan.]*

*[(99)]* **(98) Private duty nursing.** *[Private duty nursing services, n/Nursing care on a full-time basis in the member's home[,], or home health aides.*

*[(100)]* **(99) Proof of eligibility.** Documentation required by the plan to determine a dependent's qualification for health insurance coverage.

*[(101)]* **(100) Proof of prior group insurance.** Evidence in written form from an insurance company that provides verification of coverage for a given period of time.

*[(102)]* **(101) Proof of prior coverage.** If a member or his/her dependents enroll in an MCHCP plan due to loss of coverage, the member must provide proof of prior group coverage. This includes a letter from the previous insurance carrier or former employer which states all the following:

- (A) Date coverage was or will be terminated;
- (B) Reason for coverage termination; and
- (C) List of dependents covered.

*[(103)]* **(102) Prostheses.** An artificial extension that replaces a missing part of the body/. *Prostheses are typically used to replace parts lost by injury (traumatic) or missing from birth (congenital)] or [to] supplements defective parts.*

*[(104)]* **(103) Protected health information (PHI).** Any information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. This information also relates to the past, present, or future physical or mental health or condition of the individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual.

*[(105)]* **(104) Provider.** *[Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.]* A physician, hospital, medical agency, specialist, or other duly-licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-3.010(35). Other providers include but are not limited to:

- (A) Audiologist (AUD or PhD);
- (B) Certified Addiction Counselor for Substance Abuse (CAC);
- (C) Certified Nurse Midwife (CNM)—when acting within the scope of their license in the state in which they practice and performing a service which would be payable under this plan when performed by a physician;
- (D) Certified Social Worker or Masters in Social Work (MSW);
- (E) Licensed Clinical Social Worker;
- (F) Licensed Professional Counselor (LPC);
- (G) Licensed Psychologist (LP);
- (H) Nurse Practitioner (NP);
- (I) Physicians Assistant (PA);
- (J) Qualified Occupational Therapist;
- (K) Qualified Physical Therapist;
- (L) Qualified Speech Therapist;
- (M) Registered Nurse Anesthetist (CRNA);
- (N) Registered Nurse Practitioner (ARNP); or
- (O) Therapist with a PhD or Master's Degree in Psychiatry or related field.

*[(106)]* **(105) Provider directory.** A listing of network providers within a health plan.

*[(107)]* **(106) Prudent layperson.** An individual possessing an average knowledge of health and medicine.

*[(108)]* **(107) Public entity.** A state-sponsored institution of higher learning, political subdivision, or governmental entity or instrumentality that has elected to join the plan and has been accepted by the board.

*[(109)]* **(108) Qualified Medical Child Support Order (QMCSO).** A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or *[an enrollee] member* if the plan normally provides coverage for dependent children.

*[(110)]* **(109) Reconstructive surgery.** A procedure performed to restore the anatomy and/or functions of the body that are lost or impaired due to an injury or illness.

*[(111)]* **(110) Refractions.** A record of the patient's preference for the focusing of the eyes that *[can]* may then be used to purchase eyeglasses or contact lenses. It is the *[portion of the eye]* part of the exam that determines what prescription lens *[provides]* gives the patient *[with]* the best possible vision.

**[(112)](111) Rehabilitation facility.** A legally operating institution, or distinct part of an institution, that has a transfer agreement with one (1) or more hospitals and is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute hospital, and rehabilitative inpatient care, and is duly licensed by the appropriate government agency to provide such services.

(A) It does not include institutions that provide only minimal care, custodial care, ambulatory or part-time care services, or an institution that primarily provides treatment of mental/nervous disorders, substance abuse, or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission for the Accreditation of Rehabilitation Facilities.

**[(113)](112) Retiree.** A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-3.020(6)(B) and is currently receiving a monthly retirement benefit from *[one (1) of the retirement systems listed in such rule]* **a public entity.**

**[(114) Second opinion program.** *A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service.]*

**[(115)](113) Skilled nursing care.** *[Care which]* **Services that** must be performed by, or under the supervision of, licensed personnel and meets criteria as established by the claims administrator.

**[(116)](114) Skilled nursing facility (SNF).** *[An institution which meets fully each of the following requirements:*

*(A) It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board, and twenty-four (24)-hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;*

*(B) It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and*

*(C) A skilled nursing facility shall be deemed to include institutions meeting the criteria in this rule which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97).]* **A public or private facility licensed and operated according to the law that provides—**

**(A) Permanent and full-time facilities for ten (10) or more resident patients;**

**(B) A registered nurse or physician on full-time duty in charge of patient care;**

**(C) At least one (1) registered nurse or licensed practical nurse on duty at all times;**

**(D) A daily medical record for each patient;**

**(E) Transfer arrangements with a hospital; and**

**(F) A utilization review plan.**

**The facility must be primarily engaged in providing continuous skilled nursing care for persons during the recovery stage of their illness or injury, and is not, other than by coincidence, a rest home for custodial care or for the aged.**

**[(117)](115) Sound natural teeth.** Teeth and/or tissue that is viable, functional, and free of disease. A sound natural tooth has no decay,

fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

**[(118)](116) Specialty care physician/specialist.** A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

**[(119)](117) Specialty medications.** High cost drugs that are primarily self-injectible but sometimes oral medications.

**[(120)](118) State.** Missouri.

**[(121)](119) Step therapy.** Designed to encourage use of therapeutically-equivalent, lower-cost alternatives before *[stepping up to]* using more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

**[(122)](120) Subrogation.** The substitution of one (1) “party” for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the participant and recover the money directly from the other insurer.

**[(123)](121) Subscriber.** The employee or member who elects coverage under the plan.

**[(124) Subscriber only participation.** *Participation of a subscriber without participation of the subscriber’s dependents, whether or not the subscriber has dependents.]*

**[(125)](122) Surgery.** Any operative or invasive diagnostic procedure performed in the treatment of an injury or illness by an instrument or cutting procedure through any natural body opening or incision.

**[(126)](123) Surgery center (ambulatory).** A hospital-based, hospital-sponsored, or independently-owned facility that performs surgery.

**[(127)](124) Survivor.** A member who meets the requirements of subsection 22 CSR 10-3.020(6)(A).

**(125) Termination of coverage.** **The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.**

**[(128) Unemancipated child(ren).** *A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-five (25) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:*

*(A) Stepchild(ren);*

*(B) Foster child(ren) for whom the employee is responsible for health care;*

*(C) Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care; and*

*(D) Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator.*

*(E) Except for a disabled child(ren) as described in section (85) of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-five (25) (see paragraph 22 CSR 10-3.020(4)(D)2. for continuing coverage on a handicapped child(ren) beyond age twenty-five (25)); and*



*(F) Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for providing coverage is also covered as a dependent under the plan.]*

*[(129)](126)* Urgent care. Medically necessary services in order to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician office but not severe enough to require treatment in a hospital emergency department.

*[(130)](127)* Urgent care centers. Medical facilities that provide extended or twenty-four (24)-hour service to treat minor conditions at a lower cost than emergency room treatment.

*[(131)](128)* Usual, Customary, and Reasonable [C]harge.

(A) Usual—The fee a [physician] provider most frequently charges the majority of his/her patients for the same or similar services.

(B) Customary—The range of fees charged in a geographic area by [physicians] providers of comparable skills and qualifications for the same performance of similar service.

(C) Reasonable—The flexibility to take into account any unusual clinical circumstances involved in performing a particular service.

(D) A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the [doctors] providers for ninety percent (90%) of the procedures reported.

*[(132)](129)* Utilization review. Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities on a prospective, concurrent, or retrospective basis.

**(130) Vendor. The current applicable third-party administrator of MCHCP benefits.**

*[(133)](131)* Vested subscriber. A member who meets the requirements of subsection 22 CSR 10-3.020(6)(B).

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Amended: Filed Dec. 22, 2010.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-3.045 Plan Utilization Review Policy.** The Missouri Consolidated Health Care Plan is amending section (1).

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan medical plans.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program *[consists of four (4) parts, as described in the following]* has the following components:

(A) *[Precertification—The medical necessity of a non-emergency hospital admission, specified procedures as documented in the claims administrator's guidelines, and/or skilled nursing services provided on an inpatient basis must be prior authorized by the appropriate claims administrator. For emergency hospital admissions, the claims administrator must be notified within forty-eight (48) hours of the admission. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;]* **Prior authorization of services—The claims administrator must authorize some services in advance. Without prior authorization, any claim that requires prior authorization will not be covered. Participants who have another primary carrier, including Medicare, are not subject to this provision. Prior authorization does not verify eligibility or payment. Prior authorizations based on a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition will not be covered.**

**1. The following medical services are subject to prior authorization:**

**A. Ambulance services for non-emergency use whether air or ground;**

**B. Applied behavioral analysis for autism;**

**C. Cardiac and pulmonary rehabilitation after thirty-six (36) visits within a twelve (12)-week period;**

**D. Chiropractic services after twenty-six (26) visits annually;**

**E. Cochlear implant device;**

**F. Dental care to reduce trauma and restorative services when the result of accidental injury;**

**G. Durable medical equipment (DME) over one thousand five hundred dollars (\$1,500) or DME rentals over five hundred dollars (\$500) per month;**

**H. Genetic testing or counseling;**

**I. Home health care and palliative services;**

**J. Hospice care;**

**K. Hospital inpatient services except for observation stays;**

**L. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;**

**M. Nutritional counseling after three (3) sessions annually;**

**N. Orthotics over one thousand dollars (\$1,000);**

**O. Oxygen provided on an outpatient basis;**

**P. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per incident;**

**Q. Prostheses over one thousand dollars (\$1,000);**

**R. Skilled nursing facility;**

**S. Surgery (outpatient)—The following outpatient surgical procedures: potential cosmetic surgery, sleep apnea surgery, implantable stimulators, surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal**

cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams; surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth; reduction of fractures and dislocations of the jaw; excision of exostosis of jaws and hard palate; external incisions and drainage of cellulitis; incision of accessory sinuses, salivary glands, or ducts; or frenectomy); and

T. Transplants including requests related to covered travel and lodging.

2. The following pharmacy services are subject to prior authorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications. Drugs that treat chronic, complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis. The specialty medication requires frequent dosage adjustments, clinical monitoring, and special handling and are often unavailable at retail pharmacies. The specialty medication must be filled through the claims administrator's home delivery pharmacy provider;

C. Medications that may be prescribed for several conditions including some where treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. The cost of the medication exceeds nine thousand nine hundred ninety-nine dollars and ninety-nine cents (\$9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents (\$1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents (\$149.99) for compound medications.

3. Prior authorization time frames.

A. A benefit determination for non-urgent prior authorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen (15)-calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least forty-five (45) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent prior authorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

(B) Concurrent Review—The claims administrator will [continue to] monitor the medical necessity of the inpatient admission [and approve] to certify the necessity of the continued stay in the hospital. [Retirees and other participants for whom Medicare is the primary payor] Participants who have another primary carrier, including Medicare, are not subject to this provision; and

[(C) Large Case Management—Members who require long-term acute care may be offered the option of receiving the care, if appropriate, in a more cost-effective setting such as a skilled nursing facility or their own home. In some cases, this may require coverage for benefits that normally are not covered under the plan. These benefits may be provided through the approval of the claims administrator;

(D) Hospital Bill Audits—Certain hospital bills will be subject to review to verify that the services billed were actually

provided and/or the associated billed amounts are accurate and appropriate; and

(E) Penalties—Members not complying with subsections (1)(A) and (B) of this rule may be subject to a financial penalty in connection with their covered benefits.]

(C) Retrospective Review—Reviews conducted after services have been provided to a patient. The retrospective review includes an evaluation of reimbursement levels, accuracy and adequacy of documentation or coding, or settling of payment.

*AUTHORITY:* section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Amended: Filed Dec. 22, 2010.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

## Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

### PROPOSED RESCISSION

**22 CSR 10-3.050 Copay Plan Benefit Provisions and Covered Charges.** This rule established the policy of the board of trustees in regard to the Copay Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

*PURPOSE:* This rule is being rescinded because it is no longer needed.

*AUTHORITY:* section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency rescission filed Dec. 20, 2010, effective Jan. 1, 2011, expires June 29, 2011. Rescinded: Filed Dec. 20, 2010.

*PUBLIC COST:* This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED RESCISSION**

**22 CSR 10-3.051 PPO 300 Plan Benefit Provisions and Covered Charges.** This rule established the policy of the board of trustees in regard to the PPO 300 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

*PURPOSE:* This rule is being rescinded because it is no longer needed.

*AUTHORITY:* section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency rescission filed Dec. 21, 2010, effective Jan. 1, 2011, expires June 29, 2011. Rescinded: Filed Dec. 21, 2010.

*PUBLIC COST:* This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED RESCISSION**

**22 CSR 10-3.052 PPO 500 Plan Benefit Provisions and Covered Charges.** This rule established the policy of the board of trustees in regard to the PPO 500 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

*PURPOSE:* This rule is being rescinded because it is no longer needed.

*AUTHORITY:* section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency rescission filed Dec. 20, 2010, effective Jan. 1, 2011, expires June 29, 2011. Rescinded: Filed Dec. 20, 2010.

*PUBLIC COST:* This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed rescission with the

Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1), (2), and (4).

*PURPOSE:* This amendment includes changes to the policy of the board of trustees in regard to the PPO 1000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

(1) Deductible amount—Network: per individual each calendar year, one thousand dollars (\$1,000); family limit each calendar year, three thousand dollars (\$3,000). Non-network: per individual each calendar year, two thousand dollars (\$2,000); family limit each calendar year, six thousand dollars (\$6,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) The family deductible is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member deductibles may be used to meet the family deductible. Applicable charges received by one (1) family member may only meet the individual deductible amount.

(C) During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance. The newborn will not be subject to a separate deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital.

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(D) Claims [may also] shall be paid at ninety percent (90%) if required covered services are not available through a network provider within [fifty (50)] one hundred (100) miles of the member's home. The participant must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is [not permanent] for three (3) months. After three (3) months, the participant must contact the claims administrator to reassess network availability.

(4) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; [percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits;] the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

*AUTHORITY:* section 103.059, RSMo 2000. Emergency rule filed

*Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Amended: Filed Dec. 22, 2010.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions \$1,677,000 in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities \$1,677,000 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 3**

<b>Rule Number and Name:</b>	<b>22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003</b>	<b>\$1,677,000</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the public entity premium for the PPO 1000 Plan to all public entity employees who enrolled for coverage under this plan for calendar year 2011.

**IV. ASSUMPTIONS**

- Total enrollment under the PPO 1000 Plan as of January 1, 2011;
- Calendar year 2011 membership in the PPO 1000 Plan remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Calculations are based on Active Employee Only premiums and do not include dependents or retirees;
- Calculations are based on average premiums for all entities offering the PPO 1000 Plan;
- Calculations assume each public entity is contributing at least 50 percent of the premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Title:</b>	<b>22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>331 individuals enrolled in the MCHCP Public Entity PPO 1000 Plan for CY 2011</b>	<b>Individuals enrolled in the MCHCP Public Entity PPO 1000 Plan for CY 2011</b>	<b>\$1,677,000</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the public entity premium for the PPO 1000 Plan to all public entity employees who enrolled for coverage under this plan for calendar year 2011. In addition, members will pay the following copayments based upon their individual utilization of covered benefits under the PPO 1000 Plan:

- \$1,000 individual network deductible
- \$3,000 family network deductible
- \$2,000 individual non-network deductible
- \$6,000 family non-network deductible
- 10 percent network coinsurance after deductible
- 30 percent non-network coinsurance after deductible
- \$4,500 individual network out-of-pocket maximum
- \$13,500 family network out-of-pocket maximum
- \$10,000 individual non-network out-of-pocket maximum
- \$30,000 family non-network out-of-pocket maximum
- \$20 copayment for a network primary care physician office visit
- \$30 copayment for a network specialist physician office visit
- \$50 copayment for urgent care visit
- \$100 copayment for emergency room visit

**IV. ASSUMPTIONS**

- Total enrollment under the PPO 1000 Plan as of January 1, 2011;

- Calendar year 2011 membership in the PPO 1000 Plan remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Calculations are based on Active Employee Only premiums and do not include dependents or retirees;
- Calculations are based on average premiums for all entities offering the PPO 1000 Plan;
- Calculations assume each public entity is contributing at least 50 percent of the premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1), (2), and (4).

*PURPOSE:* This amendment includes changes to the policy of the board of trustees in regard to the PPO 2000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

(1) Deductible amount—Network: per individual each calendar year, two thousand dollars (\$2,000); family limit each calendar year, six thousand dollars (\$6,000). Non-network: per individual each calendar year, four thousand dollars (\$4,000); family limit each calendar year, twelve thousand dollars (\$12,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) The family deductible is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member deductibles may be used to meet the family deductible. Applicable charges received by one (1) family member may only meet the individual deductible amount.

(C) During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance. The newborn will not be subject to a separate deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital.

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(D) Claims *[may also]* shall be paid at eighty percent (80%) if required covered services are not available through a network provider within *[fifty (50)]* one hundred (100) miles of the member's home. The participant must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is *[not permanent]* for three (3) months. After three (3) months, the participant must contact the claims administrator to reassess network availability.

(4) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; *[percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits;]* the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

*PUBLIC COST:* This proposed amendment will cost state agencies or political subdivisions \$1,272,527 in the aggregate.

*PRIVATE COST:* This proposed amendment will cost private entities \$1,272,527 in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

*AUTHORITY:* section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Amended: Filed Dec. 22, 2010.



**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Name:</b>	<b>22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003</b>	<b>\$ 1,272,527</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the public entity premium for the PPO 2000 Plan to all public entity employees who enrolled for coverage under this plan for calendar year 2011.

**IV. ASSUMPTIONS**

- Total enrollment under the PPO 2000 Plan as of January 1, 2011;
- Calendar year 2011 membership in the PPO 2000 Plan remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Calculations are based on Active Employee Only premiums and do not include dependents or retirees;
- Calculations are based on average premiums for all entities offering the PPO 2000 Plan;
- Calculations assume each public entity is contributing at least 50 percent of the premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Title:</b>	<b>22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>341 individuals enrolled in the MCHCP Public Entity PPO 2000 Plan for CY 2011</b>	<b>Individuals enrolled in the MCHCP Public Entity PPO 2000 Plan for CY 2011</b>	<b>\$ 1,272,527</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the public entity premium for the PPO 2000 Plan to all public entity employees who enrolled for coverage under this plan for calendar year 2011. In addition, members will pay the following copayments based upon their individual utilization of covered benefits under the PPO 2000 Plan:

- \$2,000 individual network deductible
- \$6,000 family network deductible
- \$4,000 individual non-network deductible
- \$12,000 family non-network deductible
- 20 percent network coinsurance after deductible
- 40 percent non-network coinsurance after deductible
- \$6,000 individual network out-of-pocket maximum
- \$18,000 family network out-of-pocket maximum
- \$12,000 individual non-network out-of-pocket maximum
- \$36,000 family non-network out-of-pocket maximum
- \$25 copayment for a network primary care physician office visit
- \$35 copayment for a network specialist physician office visit
- \$50 copayment for urgent care visit
- \$100 copayment for emergency room visit

**IV. ASSUMPTIONS**

- Total enrollment under the PPO 2000 Plan as of January 1, 2011;

- Calendar year 2011 membership in the PPO 2000 Plan remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Calculations are based on Active Employee Only premiums and do not include dependents or retirees;
- Calculations are based on average premiums for all entities offering the PPO 2000 Plan;
- Calculations assume each public entity is contributing at least 50 percent of the premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-3.055 High Deductible Health Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1)–(3) and (5) and adding sections (6) and (7).

*PURPOSE:* This amendment includes changes to the policy of the board of trustees in regard to the High Deductible Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

(1) Deductible amount—Network: per individual each calendar year, one thousand two hundred dollars (\$1,200); family limit each calendar year, two thousand four hundred dollars (\$2,400). Non-network: per individual each calendar year, two thousand four hundred dollars (\$2,400); family limit each calendar year, four thousand eight hundred dollars (\$4,800).

(A) The family deductible must be met before claim payments begin, applicable when two (2) or more family members are covered.

(B) During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance. The newborn will not be subject to a separate deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital.

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(D) Claims [may also] shall be paid at eighty percent (80%) if required covered services are not available through network provider within [fifty (50)] one hundred (100) miles of the member's home. The participant must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is [not permanent.] for three (3) months. After three (3) months, the participant must contact the claims administrator to reassess network availability.

(E) Preventive care—network claims are paid at one hundred percent (100%). Non-network claims are paid at sixty percent (60%) coinsurance after the deductible.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; [percentage amount coinsurance is reduced as a result of non-compliance with prior authorization] the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) Pharmacy benefits are subject to the [applicable medical plan] High Deductible Health Plan (HDHP) deductible and coinsurance.

(6) A member does not qualify for the HDHP if they are covered under or enrolled in any of the following types of insurance plans or programs:

- (A) Medicare;
- (B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only and dependent care section;

(D) Health reimbursement account (HRA); or

(E) The participant has veteran's benefits that have been used within the past three (3) months.

(7) A member may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

*AUTHORITY:* section 103.059, RSMo 2000 and section 103.080.3, RSMo Supp. [2009] 2010. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Amended: Filed Dec. 22, 2010.

*PUBLIC COST:* This proposed amendment will cost state agencies or political subdivisions two thousand, two hundred forty-four dollars (\$2,244) in the aggregate.

*PRIVATE COST:* This proposed amendment will cost private entities two thousand, two hundred forty-four dollars (\$2,244) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 3**

<b>Rule Number and Name:</b>	<b>22 CSR 10-3.055 High Deductible Health Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003</b>	<b>\$ 2,244</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the public entity premium for the HDHP to all public entity employees who enrolled for coverage under this plan for calendar year 2011.

**IV. ASSUMPTIONS**

- Total enrollment under the HDHP as of January 1, 2011;
- Calendar year 2011 membership in the HDHP Plan remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Calculations are based on Active Employee Only premiums and do not include dependents or retirees;
- Calculations are based on average premiums for all entities offering the HDHP;
- Calculations assume each public entity is contributing at least 50 percent of the premium;
- Actual costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Title:</b>	<b>22 CSR 10-3.055 High Deductible Health Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>1 individual enrolled in the MCHCP Public Entity HDHP for CY 2011</b>	<b>Individuals enrolled in the MCHCP Public Entity HDHP for CY 2011</b>	<b>\$2,244</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the public entity premium for the HDHP to all public entity employees who enrolled for coverage under this plan for calendar year 2011. In addition, members will pay the following deductible and coinsurance amounts based upon their individual utilization of covered benefits under the HDHP:

- \$1,200 individual network deductible
- \$2,400 family network deductible
- \$2,400 individual non-network deductible
- \$4,800 family non-network deductible
- 20 percent network coinsurance after deductible
- 40 percent non-network coinsurance after deductible
- \$2,400 individual network out-of-pocket maximum
- \$4,800 family network out-of-pocket maximum
- \$4,800 individual non-network out-of-pocket maximum
- \$9,600 family non-network out-of-pocket maximum

**IV. ASSUMPTIONS**

- Total enrollment under the HDHP as of January 1, 2011;
- Calendar year 2011 membership in the HDHP remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Calculations are based on Active Employee Only premiums and do not include dependents or retirees;

- Calculations are based on average premiums for all entities offering the HDHP;
- Calculations assume each public entity is contributing at least 50 percent of the premium;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED RULE**

**22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 600 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.*

(1) Deductible amount—Network: per individual each calendar year, six hundred dollars (\$600); family limit each calendar year, one thousand two hundred dollars (\$1,200). Non-network: per individual each calendar year, one thousand two hundred dollars (\$1,200); family limit each calendar year, two thousand four hundred dollars (\$2,400).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) The family deductible is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member deductibles may be used to meet the family deductible. Applicable charges received by one (1) family member may only meet the individual deductible amount.

(C) During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance. The newborn will not be subject to a separate deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if he/she is transferred to another hospital.

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims—are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims shall be paid at ninety percent (90%) if the subscriber requires covered services that are not available through a network provider within one hundred (100) miles of his/her home. The participant must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is for three (3) months. After three (3) months, the participant must contact the claims administrator to reassess network availability.

(E) Preventive care—network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network out-of-pocket maximum for individual—one thousand five hundred dollars (\$1,500).

(B) Network out-of-pocket maximum for family—three thousand dollars (\$3,000).

(C) Non-network out-of-pocket maximum for individual—three thousand dollars (\$3,000).

(D) Non-network out-of-pocket maximum for family—six thousand dollars (\$6,000).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include:

claims for services paid at one hundred percent (100%); charges above the usual, customary, and reasonable limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(4) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Original rule filed Dec. 22, 2010.*

*PUBLIC COST: This proposed rule will cost state agencies or political subdivisions \$2,000,293 in the aggregate.*

*PRIVATE COST: This proposed rule will cost private entities \$2,000,293 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*



**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 3**

<b>Rule Number and Name:</b>	<b>22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003</b>	<b>\$ 2,000,293</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the public entity premium for the PPO 600 Plan to all public entity employees who enrolled for coverage under this plan for calendar year 2011.

**IV. ASSUMPTIONS**

- Total enrollment under the PPO 600 Plan as of January 1, 2011;
- Calendar year 2011 membership in the PPO 600 Plan remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Calculations are based on Active Employee Only premiums and do not include dependents or retirees;
- Calculations are based on average premiums for all entities offering the PPO 1000 Plan;
- Calculations assume each public entity is contributing at least 50 percent of the premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual costs will vary based upon actual utilization of services.

- Calculations assume each public entity is contributing at least 50 percent of the premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 3**

<b>Rule Number and Title:</b>	<b>22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>422 individuals enrolled in the MCHCP Public Entity PPO 600 Plan for CY 2011</b>	<b>Individuals enrolled in the MCHCP Public Entity PPO 600 Plan for CY 2011</b>	<b>\$ 2,000,293</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the public entity premium for the PPO 600 Plan to all public entity employees who enrolled for coverage under this plan for calendar year 2011. In addition, members will pay the following copayments based upon their individual utilization of covered benefits under the PPO 600 Plan:

- \$600 individual network deductible
- \$1,200 family network deductible
- \$1,200 individual non-network deductible
- \$2,400 family non-network deductible
- 10 percent network coinsurance after deductible
- 30 percent non-network coinsurance after deductible
- \$1,500 individual network out-of-pocket maximum
- \$3,000 family network out-of-pocket maximum
- \$3,000 individual non-network out-of-pocket maximum
- \$6,000 family non-network out-of-pocket maximum

**IV. ASSUMPTIONS**

- Total enrollment under the PPO 600 Plan as of January 1, 2011;
- Calendar year 2011 membership in the PPO 600 Plan remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Calculations are based on Active Employee Only premiums and do not include dependents or retirees;
- Calculations are based on average premiums for all entities offering the PPO 600 Plan;

- Calculations assume each public entity is contributing at least 50 percent of the premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED RULE**

**22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the Medical Plan Benefit Provisions and Covered Charges for participation in the Missouri Consolidated Health Care Plan.*

(1) Benefit Provisions Applicable to the PPO 600, PPO 1000, PPO 2000, and High Deductible Health Plan (HDHP) Plans. Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a participant while covered under the plans, provided the deductible requirement, if any, is met.

(2) Covered Charges Applicable to the PPO 600, PPO 1000, PPO 2000, and HDHP Plans.

(A) Only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a noncovered service, and which are—

1. Prescribed by a doctor or provider for the therapeutic treatment of injury or sickness;
2. To the extent they do not exceed any limitation;
3. Not excluded by the limitations; and
4. For not more than the usual, reasonable, and customary charge as determined by the claims administrator for the services provided, will be considered covered charges.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, reasonable, and customary, the claims administrator will consider the following:

1. The medical benefits or supplies usually rendered or prescribed for the condition; and
2. The usual, reasonable, and customary charges in the area in which services and/or supplies are provided.

(C) A physician visit to seek a second opinion is a covered service.

(D) Plan benefits for the PPO 600, PPO 1000, PPO 2000, and HDHP Plans are as follows:

PUBLIC ENTITY BENEFITS	
<b>Allergy Serum</b> <b>Multi-dose vial</b>	
No coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers or air ventilation system cleaning.	
<b>Ambulance Service</b>	
Non-emergency air or ground excluded unless prior authorization received from medical plan.	
Use of air ambulance or medical helicopter service from any continent returning to the U.S. is excluded.	
<b>Applied Behavioral Analysis for Autism</b> <b>For children younger than age 19</b>	
The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of observation, measurement and functional analysis of the relationship between environment and behavior.	
\$40,000 annual limit. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary.	
Prior authorization by medical plan required.	
<b>Birth Control Prescriptions</b>	
<b>Birth Control Devices and Injections</b>	
Administered in the physician's office.	
<b>Cardiac and Pulmonary Rehabilitation</b>	
Up to 36 visits within a 12-week period per incident	
Prior authorization by medical plan required after 36 visits within a 12-week period.	
<b>Chelation Therapy</b>	
Limited to treatment of lead poisoning in children as recommended by Missouri Department of Health and Senior Services.	
<b>Chiropractic Services</b>	
Up to 26 visits annually	
Prior authorization by medical plan required after 26 visits annually.	
<b>Cochlear Implant Device</b>	
Prior authorization by medical plan required.	
<b>Colonoscopy</b>	
<b>Convenient Care Clinic (CCC)</b>	

**Dental Care/Accidental Injury**

Treatment to reduce trauma and restorative services only when the result of accidental injury to sound, natural teeth and tissue that are viable, functional and free of disease. Oral surgery is covered when medically necessary as a direct result of injury, tumors or cysts. Treatment must be initiated within 60 days of accident.

No coverage for dental care, including oral surgery, as a result of poor dental hygiene.

Prior authorization by medical plan required.

**Durable Medical Equipment (DME)/Medically Necessary Disposable Supplies**

Basic equipment that meets medical needs. DME includes, but is not limited to, augmentative communication devices and manual and powered mobility devices. Includes repair and replacement due to normal wear and tear, if there is a change in medical condition or if growth-related. Disposable supplies that do not withstand prolonged use and are periodically replaced include, but are not limited to, colostomy and ureterostomy bags and prescription compression stockings.

No coverage for non-reusable disposable supplies including but not limited to bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinence pads, irrigating kits, pressure leotards, surgical leggings and support hose, over-the-counter medications and supplies including oral appliances.

Prior authorization by medical plan required for durable medical equipment over \$1,500 and/or rentals over \$500/month.

Prescription compression stockings are limited to two pairs or four individual stockings per plan year.

**Emergency Room Services**

If admitted to hospital, may be required to transfer to network facility for maximum benefit. Paid as network benefit.

**Enteral Feedings (Tube Feeding)**

Nutritional supplements that are prescribed by a physician and administered through enteral feedings, provided they are the sole source of nutrition and the member has a permanent condition, or partial nutrition during transition. This includes nutritional and electrolyte supplements and supplies related to enteral feedings (for example, feeding tubes, pumps and other materials used to administer enteral feedings).

**Flu Shot/Nasal Spray (FluMist®)**

Covered at 100% when administered in a network physician's office. When shot is obtained elsewhere, the member must submit a receipt and a Non-Network Flu Shot Reimbursement form to medical plan to receive reimbursement up to \$25. Multiple vaccinations covered if recommended by the Missouri Department of Health and Senior Services or by the Centers for Disease Control and Prevention.

**Genetic Testing or Counseling**

Genetic testing or counseling as part of treatment for a medical condition

No coverage for testing based on family history.

Prior authorization by medical plan required.

<b>Hair Analysis and Prostheses</b> Limited to prostheses and expenses for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata or alopecia totalis for children 18 years of age or younger. Annual maximum \$200. Lifetime maximum \$3,200.  No coverage for services related to the analysis of hair unless used as a diagnostic tool to determine poisoning.
<b>Hearing Aids (Per Ear)</b> Covered once every two years. Member pays coinsurance amount per hearing aid. If hearing aid cost exceeds the amount listed below, member is also responsible for charges over that amount.  Conventional: \$1,000 Programmable: \$2,000 Digital: \$2,500 BAHA: \$3,500
<b>Hearing Testing</b> One hearing test per year. Additional hearing tests are covered if recommended by physician.
<b>Home Health Care/Palliative Services</b>  Prior authorization by medical plan required.
<b>Hospice Care</b> Inpatient or Outpatient Includes bereavement and respite care.  Prior authorization by medical plan required.
<b>Hospital Benefits - Inpatient Room and Board</b> Based on semi-private room <ul style="list-style-type: none"> <li>• Medical (including outpatient services)</li> <li>• Mental Health (including outpatient services)</li> <li>• Chemical Dependency (including outpatient services)</li> <li>• Observation for Medical, Mental Health or Chemical Dependency</li> </ul> Except for observation, prior authorization by medical plan required.
<b>Immunizations (Age-appropriate Adult and Pediatric)</b> Specified schedule of immunizations including, but not limited to, polio, rubella, measles, mumps, tetanus, whooping cough, diphtheria, hepatitis A and B, haemophilus influenzae type B (Hib), human papillomavirus, shingles, chicken pox, meningitis and pneumonia.  Not covered when requested by third party or for travel.  Immunizations required by the Missouri Department of Health and Senior Services or recommended by the Centers for Disease Control and Prevention.
<b>Injections and Infusions</b> Administered in the physician's office.
<b>Lab and X-ray</b>
<b>Mammograms</b> One mammogram per year. Additional mammograms are covered if recommended by physician.



**Mastectomies**

**No time frame on receiving reconstructive surgery or prostheses after mastectomies necessary to restore symmetry, as recommended by physician.**

**Maternity Coverage**

**Newborns and their mothers are allowed hospital stays of at least 48 hours after normal birth and 96 hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two-visit minimum, at least one in the home.**

**Prior authorization by medical plan required for maternity stays longer than 48 hours (normal delivery) or 96 hours (C-section).**

**Mental Health/Chemical Dependency (Office Visit)**

**Nutrient Supplements**

**Formula and low-protein modified food products recommended by physician and limited only to treatment of Phenylketonuria (PKU) or any inherited disease of amino and organic acids**

**Nutritional Counseling**

**Up to three sessions annually with registered dietitian, not limited by diagnosis. Up to three additional sessions considered with referral and medical diagnosis.**

**Prior authorization by medical plan required after three sessions annually.**

**Office Visit**

**Primary Care Physicians**

**Specialists**

**Orthotics****Therapeutic Shoes for Diabetics**

Therapeutic shoes, inserts, and/or modifications to therapeutic shoes are covered if the following criteria are met:

- The patient has diabetes mellitus; and
- The patient has one or more of the following conditions:
  - Previous amputation of the other foot, or part of either foot, or
  - History of previous foot ulceration of either foot, or
  - History of pre-ulcerative calluses of either foot, or
  - Peripheral neuropathy with evidence of callus formation of either foot, or
  - Foot deformity of either foot, or
  - Poor circulation in either foot; and
- The certifying physician who is managing the patient's systemic diabetes condition has certified that indications noted in this *Therapeutic Shoes for Diabetics* section are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes.

For adult patients meeting these criteria, coverage is limited to one of the following within one year:

- One pair of custom molded shoes (which includes inserts provided with these shoes) and 2 additional pairs of inserts; or
- One pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes).

Separate inserts may be covered and dispensed independently of diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed. This footwear must meet the definitions found in this policy for depth shoes or custom molded shoes.

See Orthopedic Footwear benefit.

There is no separate payment for the fitting of the shoes, inserts, or modifications or for the certification of need or prescription of the footwear.

**Spinal Orthoses**

A thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the trunk; or
- To facilitate healing following an injury to the spine or related soft tissues; or
- To facilitate healing following a surgical procedure on the spine or related soft tissue; or
- To otherwise support weak spinal muscles and/or a deformed spine.

**Helmets**

Helmets are provided when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living. These devices are not provided for use during sports-related activities.

**Cranial Orthosis for Plagiocephaly**

Plagiocephaly describes an asymmetrically shaped head. Synostotic plagiocephaly (craniosynostosis) is due to the premature closure of the cranial sutures. In non-synostotic plagiocephaly, also referred to as positional or deformational, the cranial sutures remain open. Cranial orthosis is the use of a special helmet or band on the head, which aids in molding the shape of the cranium to normal. Dynamic orthotic craniotherapy, which may also be referred to as cranial molding, molding helmet, cranial banding, or cranial orthosis, is considered medically necessary only as an adjunct to operative therapy following surgery for craniosynostosis. Molding helmet therapy, including dynamic orthotic craniotherapy, is not a covered benefit for the non-operative management of positional or non-synostotic plagiocephaly.

Initial reimbursement shall cover any subsequent revisions.

#### **Cervical Orthoses**

A cervical orthosis is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the neck; or
- To facilitate healing following an injury to the cervical spine or related soft tissues; or
- To facilitate healing following a surgical procedure on the cervical spine or related soft tissue; or
- To otherwise support weak cervical muscles and/or a deformed cervical spine.

#### **Hip Orthoses**

A hip orthosis is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the hip; or
- To facilitate healing following an injury to the hip or related soft tissues; or
- To facilitate healing following a surgical procedure on the hip or related soft tissue; or
- To otherwise support weak hip muscles and/or a hip deformity.

#### **Knee Orthoses**

A knee orthosis is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the knee; or
- To facilitate healing following an injury to the knee or related soft tissues; or
- To facilitate healing following a surgical procedure on the knee or related soft tissue; or
- To otherwise support weak knee muscles and/or a knee deformity.

These devices are not provided solely for use during sports-related activities.

#### **Ankle-Foot/Knee-Ankle-Foot (AFO) Orthoses**

##### **AFOs Not Used During Ambulation**

A static AFO is covered if the following criteria are met:

- Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a non-fixed contracture); and,
- Reasonable expectation of the ability to correct the contracture; and,
- Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and,
- Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; OR
- The patient has plantar fasciitis.

If a static AFO is used for the treatment of a plantar flexion contracture, the pre-treatment passive range of motion must be measured with a goniometer and documented in the medical record. There must be documentation of an appropriate stretching program carried out by professional staff or caregiver. A static AFO and replacement interface will be denied as not medically necessary if the contracture is fixed. A static AFO and replacement interface will be denied as not medically necessary for a patient with a foot drop but without an ankle flexion contracture. A component of a static AFO that is used to address positioning of the knee or hip will be denied as not medically necessary because the effectiveness of this type of component is not established.

If a static AFO is covered, a replacement interface is covered as long as the patient continues to meet indications and other coverage rules for the splint. Coverage of a replacement interface is limited to a maximum of one (1) per 6 months. Additional interfaces will be denied as not medically necessary. A foot drop splint/recumbent positioning device and replacement interface will be denied as not medically necessary in a patient with foot drop who is non-ambulatory because there are other more appropriate treatment modalities.

##### **AFOs and KAFOs Used During Ambulation**

AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally.

**Knee–ankle–foot orthoses (KAFO)** are covered for ambulatory patients for whom an ankle–foot orthosis is covered and for whom additional knee stability is required.

If the basic coverage criteria for an AFO or KAFO are not met, the orthosis will be denied as not medically necessary. AFOs and KAFOs that are molded-to-patient-model, or custom-fabricated, are covered for ambulatory patients when the basic coverage criteria listed above and one of the following criteria are met:

- The patient could not be fit with a prefabricated AFO, or
- The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months), or
- There is a need to control the knee, ankle or foot in more than one plane, or
- The patient has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury, or
- The patient has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

Current Procedural Terminology (CPT) L-coded additions to AFOs and KAFOs will be denied as not medically necessary if either the base orthosis is not medically necessary or the specific addition is not medically necessary.

#### **Foot Orthosis**

Custom, removable foot orthoses are considered medically necessary for members who meet the following criteria:

- Member has any of the following conditions:
  - Adults (skeletally mature feet):
    - Acute plantar fasciitis
    - Acute sport-related injuries (including: diagnoses related to inflammatory problems; e.g., bursitis, tendonitis)
    - Calcaneal bursitis (acute or chronic)
    - Calcaneal spurs (heel spurs)
    - Conditions related to diabetes (see section above on therapeutic shoes for diabetes for a complete list of medically necessary diagnoses)
    - Inflammatory conditions (i.e., sesamoiditis; submetatarsal bursitis; synovitis; tenosynovitis; synovial cyst; osteomyelitis; and plantar fascial fibromatosis)
    - Medial osteoarthritis of the knee (lateral wedge insoles)
    - Musculoskeletal/arthropathic deformities (including: deformities of the joint or skeleton that impairs walking in a normal shoe; e.g. bunions, hallux valgus, talipes deformities, pes deformities, anomalies of toes)
    - Neurologically impaired feet (including: neuroma; tarsal tunnel syndrome; ganglionic cyst; and neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease)
    - Vascular conditions (including: ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), chronic thrombophlebitis).
  - Children (skeletally immature feet):
    - Hallux valgus deformities
    - In-toe or out-toe gait
    - Musculoskeletal weakness (e.g., pronation, pes planus)
    - Structural deformities (e.g., tarsal coalitions)
    - Torsional conditions (e.g., metatarsus adductus, tibial torsion, femoral torsion)

#### **Orthopedic Footwear**

Orthopedic footwear is covered for adults if it is an integral part of a covered leg brace. Oxford shoes

are covered in these situations. Other shoes, e.g. high top, depth inlay or custom for non-diabetics, etc., are also covered if they are an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace. Heel replacements, sole replacements, and shoe transfers involving shoes on a covered brace are also covered. Inserts and other shoe modifications are covered if they are on a shoe that is an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace.

A shoe and related modifications, and heel/sole replacements, are covered only when the shoe is an integral part of a brace. A matching shoe which is not attached to a brace is non-covered.

Shoes which are incorporated into a brace must be billed by the same supplier billing for the brace.

#### **Upper Limb Orthoses**

An upper limb orthosis is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the joint(s)
- To facilitate healing following an injury to the joint(s) or related soft tissues
- To facilitate healing following a surgical procedure on the joint(s) or related soft tissue

#### **Elastic Supports**

Elastic supports are covered when they are ordered for one of the following indications:

- Severe or incapacitating vascular problems, such as
  - acute thrombophlebitis
  - massive venous stasis'
  - pulmonary embolism
- Venous insufficiency
- Varicose veins
- Edema of lower extremities
- Edema of pregnancy
- Lymphedema

#### **Trusses**

Trusses are covered when a hernia is reducible with the application of a truss.

#### **Orthotic-Related Supplies**

Orthotic-related supplies are covered when the device with which it is used is covered and they are necessary for the function of the orthotic device.

#### **Cast Boot, Post-Operative Sandal or Shoe, Healing Shoe**

A cast boot or post-operative sandal or shoe is covered when it is medically necessary for one of the following indications:

- to protect a cast from damage during weight-bearing activities following injury or surgery;
- to provide appropriate support and/or weight-bearing surface to a foot following surgery;
- to promote good wound care and healing via appropriate weight distribution and foot protection; or
- when the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

#### **Specific Exclusions**

Non-covered devices and supplies include, but are not limited to, all of the following:

- Experimental or investigational devices
- Items for the patient's comfort or convenience or for the convenience of the patient's caregiver(s)
- Items to have on hand for backup or duplicates to have available at various locations
- Devices and supplies for residents of nursing facilities
- Equipment or supplies covered by another agency

#### **Replacing Orthotic Devices**

**When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item. A replacement is subject to review of medical necessity. The plan will take into account the anticipated life expectancy of the device.**

**Prior authorization by medical plan required for orthotics over \$1,000**

#### **Outpatient Diagnostic Procedures**

**Including, but not limited to, diagnostic sigmoidoscopies, endoscopies, sleep studies, ultrasounds, electroencephalograms (EEGs) and electrocardiograms (EKGs)**

**Oxygen**

**Outpatient**

**Go to DURABLE MEDICAL EQUIPMENT in this section.**

**Prior authorization by medical plan required.**

#### **Physical, Speech and Occupational Therapy and Rehabilitation Services - Outpatient**

**Up to 60 combined visits allowed per incident if showing significant improvement. Aquatic therapy must be performed by physical therapist to be covered.**

#### **Speech Therapy:**

**Covered as medically necessary for either of the following:**

- **A prescribed course of speech therapy by an appropriate healthcare provider for the treatment of a severe impairment of speech/language and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests that measure the extent of the impairment, performance deviation, and language and pragmatic skills assessment levels.**
- **A prescribed course of voice therapy by an appropriate healthcare provider for a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury ( e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery).**

**When all of the following criteria are met:**

- **The treatment being recommended has the support of the treating physician;**
- **The therapy being ordered requires the one-to-one intervention and supervision of a speech-language pathologist;**
- **The therapy plan includes specific tests and measures that will be used to document significant progress every two weeks;**
- **Meaningful improvement is expected from the therapy and**
- **The treatment includes a transition from one-to-one supervision to an individual or caregiver provided maintenance program upon discharge.**

**Speech or voice therapy is not covered in any of the following situations:**

- **Any computer-based learning program for speech or voice training purposes**
- **School speech programs**
- **Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy)**
- **Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs)**
- **Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver**

- Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work
- Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences
- Therapy or treatment provided to improve or enhance job, school or recreational performance
- Long-term rehabilitative services when significant therapeutic improvement is not expected

**Physical Therapy:**

Covered as a prescribed course of physical therapy by an appropriate healthcare provider as medically necessary when all of the following criteria are met:

- The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect or surgery;
- The program is expected to result in significant therapeutic improvement over a clearly defined period of time and
- The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.

Physical therapy is not covered for the following:

- Treatment provided to prevent or slow deterioration in function or prevent reoccurrences
- Treatment intended to improve or maintain general physical condition
- Long-term rehabilitative services when significant therapeutic improvement is not expected
- Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g. occupational therapy)
- Work hardening programs
- Back school
- Vocational rehabilitation programs and any program with the primary goal of returning an individual to work
- Group physical therapy (because it is not one-on-one, individualized to the specific person's needs)
- Services for the purpose of enhancing athletic performance or for recreation

**Occupational Therapy:**

Covered as prescribed course of occupational therapy by an appropriate healthcare provider as medically necessary when all of the following criteria are met:

- The program is designed to improve or compensate for lost or impaired physical functions, particularly those impacting activities of daily living, resulting from illness, injury, congenital defect, or surgery;
- The program is expected to result in significant therapeutic improvement over a clearly defined period of time and
- The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.

Occupation Therapy is not covered for the following:

- Treatment provided to prevent or slow deterioration in function or prevent reoccurrences
- Treatment intended to improve or maintain general physical condition

- Long-term rehabilitative services when significant therapeutic improvement is not expected
- Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g. physical therapy)
- Work hardening programs
- Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work
- Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs)
- Driving safety/driver training

Prior authorization by medical plan required after 60 combined visits per incident.

#### Physician Charges

##### Preventive Services

- Services recommended by the U.S. Preventive Services Task Force (categories A and B)
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration
- Preventive care and screenings for women supported by the Health Resources and Services Administration

Annual physical exams (Well man, woman and child) -  
one per calendar year

##### Age-specific cancer screenings:

- Mammograms
- Pap smears
- Prostate cancer screenings
- Colorectal screenings
- Colonoscopy and sigmoidoscopy screenings

For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.

#### Prostheses (Prosthetic Devices)

Basic equipment that meets medical needs

Repair and replacement not covered unless due to normal wear and tear, if there is a change in medical condition or if growth-related.

Prior authorization by medical plan required for prostheses over \$1,000.

#### Skilled Nursing Facility

Benefits are limited to 120 days per calendar year.

Prior authorization by medical plan required.



**Surgery (Inpatient and Outpatient)**

**Includes sterilization**

**Prior authorization by medical plan required for outpatient surgeries:**

- Potential cosmetic surgery
- Sleep Apnea surgery
- Implantable Stimulators
- All outpatient surgeries with procedure codes ending in T (temporary codes used for data collection, experimental, investigational or unproven surgeries)
- Outpatient spinal surgeries including but not limited to artificial disc replacement, fusions, non-pulsed radiofrequency denervation, vertebroplasty/kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure.

**Oral surgery**

- Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological exams
- Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth
- Reduction of fractures and dislocations of the jaw
- Excision of exostosis of jaws and hard palate
- External incision and drainage of cellulitis
- Incision of accessory sinuses, salivary glands or ducts
- Frenectomy

**Transplants**

**When neither experimental nor investigational and medically necessary: bone marrow, cornea, kidney, liver, heart, lung, pancreas, intestinal or any combination. Includes services related to organ procurement and donor expenses if not covered under another plan.**

**Contact medical plan for arrangements, prior authorization and transplant network.**

**Travel, if approved, is limited to \$10,000 maximum per transplant.**

**Network**

**Includes travel and lodging allowance for recipient and his or her immediate family travel companion (younger than 19, both parents) if transplant facility is more than 100 miles from residence.**

**Lodging: Maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to [www.gsa.gov](http://www.gsa.gov) for per diem rates.**

**Travel: IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).**

**Meals: Not covered.**

**Prior authorization by medical plan required.**

**Non-network**

**Reimbursement limited to maximum schedule. Charges above the maximum are your responsibility and do not apply to your deductible or out-of-pocket maximum.**

**Travel, lodging and meals not covered.**

**Prior authorization by medical plan required.**

**Urgent Care**

**Paid as network benefit.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Original rule filed Dec. 22, 2010.*

*PUBLIC COST: This proposed rule will cost state agencies or political subdivisions \$4,949,819 in the aggregate.*

*PRIVATE COST: This proposed rule will cost private entities \$4,949,819 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Name:</b>	<b>22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003</b>	<b>\$4,949,819</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the public entity premium for all public entity employees who enrolled for coverage under this plan for calendar year 2011.

**IV. ASSUMPTIONS**

- Total enrollment under the all public entity plans as of January 1, 2011;
- Calendar year 2011 membership in the public entity plans remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Calculations are based on Active Employee Only premiums and do not include dependents or retirees;
- Calculations are based on average premiums for all public entities;
- Calculations assume each public entity is contributing at least 50 percent of the premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Title:</b>	<b>22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>1,411 individuals enrolled in MCHCP public entity plans for CY 2011</b>	<b>Individuals enrolled in MCHCP public entity plans for CY 2011</b>	<b>\$4,949,819</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the public entity premium for all public entity employees who enrolled for coverage under this plan for calendar year 2011.

**IV. ASSUMPTIONS**

- Total enrollment under all public entity plans as of January 1, 2011;
- Calendar year 2011 membership in the all public entity plans remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Calculations are based on Active Employee Only premiums and do not include dependents or retirees;
- Calculations are based on average premiums for all public entities;
- Calculations assume each public entity is contributing at least 50 percent of the premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-3.060 [PPO 300 Plan,] PPO [500] 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP[, and Copay] Plan**  
**Limitations.** The Missouri Consolidated Health Care Plan is deleting sections (2), (33), (48), (50), (52), and (57); amending the rule title, rule purpose, and sections (1), (7), (8), (11)–(13), (26), (28), (30), (31), (37), (45), (49), (51), and (53); adding new sections (3), (6), (7), (9)–(11), (15), (16), (30), (33), (37), (41), (42), (48), (54), (56), and (63); and renumbering as necessary.

*PURPOSE: This amendment includes changes by the board of trustees in regard to the limitations and exclusions of the Missouri Consolidated Health Care Plan PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP Plan.*

*PURPOSE: This rule establishes the limitations and exclusions of the Missouri Consolidated Health Care Plan [PPO 300 Plan,] PPO [500] 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP[, and/or Copay] Plan.*

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges *[or within any of the sections of this rule]*. **In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein.**

*[(2) If applicable, all hospitalizations, outpatient treatment for chemical dependency, or mental and nervous disorder that do not receive prior authorization as described in 22 CSR 10-2.045, reimbursement will be reduced by ten percent (10%) of reasonable and customary charges.]*

*[(3)](2)* Abortion—other than situations where the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

(3) **Acts of war—injury or illness caused, or contributed to, by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.**

(6) **Assistant surgeon services—not covered unless determined to meet the clinical eligibility for coverage under the plan.**

(7) **Athletic trainer services—services by a licensed athletic trainer not covered.**

*[(6)](8)* Autopsy.

(9) **Bariatric procedures—not covered except for members who have undergone bariatric procedures before December 31, 2010, that were approved by the medical plan will receive follow-up care until December 31, 2011. Revisions and corrections of bariatric procedures are covered only when the revision is used to treat life-threatening complications (e.g., wound infection, abscess, dehiscence, gastric leaking, and embolism).**

(10) **Blood donor expenses—not covered.**

(11) **Blood pressure cuffs/monitors—not covered.**

*[(7)](12)* Blood storage[,]**—not covered**, including whole blood, blood plasma, and blood products.

*[(8)](13)* Breast augmentation mammoplasty—not covered unless associated with breast surgery following a medically necessary mastectomy incurred secondary to active disease.

*[(9)](14)* Care received without charge.

(15) **Charges resulting from the failure to appropriately cancel a scheduled appointment.**

(16) **Childbirth classes.**

*[(10)](17)* Comfort and convenience items.

*[(11)](18)* Cosmetic, plastic, reconstructive, or restorative surgery—unless medically necessary to repair a functional disorder caused by disease[,] **or** injury, or congenital defect or abnormality (for a participant under the age of nineteen (19)), or to restore symmetry following a mastectomy.

*[(12)](19)* Custodial or domiciliary care—includes services and supplies that assist members in the activities of daily living like walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets *[and]*; supervision of medication that is usually self-administered; **or other services that can be provided by persons without the training of a health care provider.**

*[(13)](20)* Dental—treatment must be initiated within sixty (60) days of accident. Limited to treatment of accidental injury to sound, natural teeth **and tissue that are viable, functional, and free of disease.** Oral surgery is covered only when medically necessary as a direct result from injury, tumors, or cysts. Dental care, including oral surgery, as a result of poor dental hygiene is not covered. Extractions of bony or partial bony impactions are excluded.

*[(14)](21)* Durable medical equipment and disposable supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings, and support hose. Over-the-counter medications and supplies. Prescription compression stockings are limited to two (2) pairs of four (4) individual stockings per plan year.

*[(15)](22)* Educational or psychological testing—not covered unless part of a treatment program for covered services.

*[(16)](23)* Examinations requested by a third party.

*[(17)](24)* Excessive charges—any otherwise eligible expenses that exceed the maximum allowance or benefit limit.

*[(18)](25)* Exercise equipment.

*[(19)](26)* Experimental services or investigational services—experimental or investigational services, procedures, supplies, or drugs as determined by the claims administrator are not covered, except clinical trials for cancer treatment as specified by law.

*[(20)](27)* Eye glasses and contact lenses—charges incurred in connection with the fitting of eye glasses or contact lenses except for initial placement immediately following cataract surgery.

*[(21)](28)* Eye services—health services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

*[(22)](29)* Services obtained at a government facility—not covered if care is provided without charge.

**(30) Gender reassignment—health services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment.**

*[(23)](31) Hair analysis, wigs, and hair transplants—services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also, hairstyling wigs, hairpieces, and hair prostheses, including those ordered by a participating provider, are not covered. Such items and services are not covered except for members ages eighteen (18) and under with alopecia as specified by law. Subject to two hundred dollar (\$200) annual maximum and three thousand two hundred dollar (\$3,200) lifetime maximum.*

*[(24)](32) Health and athletic club membership—including costs of enrollment.*

**(33) Home births.**

*[(25)](34) Immunizations requested by third party or for travel.*

*[(26)](35) Infertility treatment. [—Infertility treatments are limited to in-vivo (intrauterine, intracervical, intravaginal fertilization). Those health services and associated expenses for the treatment of infertility are not covered, including reversal of voluntary sterilization, intracytoplasmic sperm injection (ICSI), in vitro fertilization, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT) procedures; embryo transport; donor sperm and related cost for collection; no cryopreservation of sperm or eggs; and non-medically necessary amniocentesis.]*

*[(27)](36) Level of care, if greater than is needed for the treatment of the illness or injury.*

**(37) Long-term care.**

*[(28)](38) Medical care and supplies—not to the extent that they are payable under—*

*(A) A plan or program operated by a national government or one (1) of its agencies; or*

*(B) Any state's cash sickness or similar law, including any group insurance policy approved under such law.*

*[(29)](39) Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the [subscriber] participant, such as a spouse, parent, child, sibling, or brother/sister-in-law.*

*[(30)](40) Military service connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.*

**(41) Never events—twenty-eight (28) occurrences on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting. They are defined as adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.**

**(42) Nocturnal enuresis alarm.**

*[(31)](43) Non-network providers—subject to **higher** deductible and non-network coinsurance.*

*[(32)](44) Not medically necessary services—with the exception of preventive services.*

*[(33)] Obesity—medical and surgical intervention is not covered, unless the member meets the definition of severe morbid obesity as defined in 22 CSR 10-3.010 and satisfies all requirements described in the plan. Bariatric surgery will only be covered when prior authorization is received from the medical plan.*

*(A) Bariatric surgery additional qualifying criteria—*

*1. Presence of severe morbid obesity that has persisted for at least five (5) years defined as body mass index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions will be considered based on clinical review;*

*2. Member must be eighteen (18) years of age or older;*

*3. Documented evidence of at least two (2) failed attempts at weight loss each with a minimum duration of at least six (6) months with the member achieving at least a ten percent (10%) weight loss and meeting the following additional criteria: one (1) attempt must be in a physician-supervised weight loss program and fully documented in the physician's record; the program must use a multidisciplinary approach including dietician consultation, low-calorie diet, increased physical activity, and behavioral modification; nationally recognized program such as Jenny Craig or Weight Watchers (This does not include self-directed low-calorie diets such as the Atkins Diet or South Beach Diet.); and the most recent attempt must have been within the twelve (12)-month period prior to the requested surgery;*

*4. Documented evidence the member is on a nutrition and exercise program immediately prior to the surgery request;*

*5. Evidence the member and the attending physician have a life-long plan for compliance with lifestyle modification requirements;*

*6. Documentation the member has completed a psychological evaluation and, if appropriate, behavior modification and should be free of major psychiatric diagnosis or a current behavior which would significantly reduce long-term effectiveness of the proposed treatment; and*

*7. Procedure must be performed at a Centers of Excellence (COE) facility for Bariatric Surgery as determined by the Centers for Medicare and Medicaid Services.*

*(B) Network services are limited to one (1) operative procedure for the treatment of obesity per lifetime. Non-network obesity services are not covered.*

*(C) Revisions and corrections of bariatric procedures only when the revision or correction is used to treat life-threatening complications (e.g., wound infection, abscess, dehiscence, gastric leaking, and embolism). Coverage is limited to the following bariatric procedures: Roux-en-Y Gastric Bypass—open and laparoscopic (RYGBP), Laparoscopic Adjustable Gastric Banding (LAGB), and Open and Laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS).]*

*[(34)](45) Orthognathic surgery.*

*[(35)](46) Orthoptics.*

*[(36)](47) Other charges—no coverage for charges that would not be incurred if the subscriber was not covered. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan. Miscellaneous service charges—telephone consultations,*

charges for failure to keep scheduled appointment (unless the scheduled appointment was for a mental health service), or any late payment charge.

**(48) Outpatient birthing centers.**

*[(37)](49)* Over-the-counter medications—except for insulin and drugs recommended by the U.S. Preventive Services Task Force (Categories A and B) as prescribed by a physician and included on the formulary through the pharmacy benefit.

*[(38)](50)* Over-the-counter supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings, and support hose.

*[(39)](51)* Physical fitness.

*[(40)](52)* Physical, speech, and occupational therapy—health services and associated expenses for development delay. Treatment for disorders relating to delays in learning, motor skills, and communications.

*[(41)](53)* Private duty nursing.

**(54) Prognathic and maxillofacial surgery.**

*[(42)](55)* Prosthetic repair or replacement—not covered unless due to normal wear and tear, if there is a change in medical condition, if growth related, or medically necessary.

**(56) Self-inflicted injuries—not covered unless related to a mental diagnosis.**

*[(43)](57)* Services not specifically included as benefits.

*[(44)](58)* Services rendered after termination of coverage—those services otherwise covered under the agreement, but rendered after the date coverage under the agreement terminates, including services for medical conditions arising prior to the date individual coverage under the agreement terminates.

*[(45)](59)* Stimulators (for bone growth)—not covered unless **prior** authorized by claims administrator **and clinical eligibility is met**.

*[(46)](60)* Surrogacy—pregnancy coverage is limited to plan member.

*[(47)](61)* Temporomandibular Joint Syndrome (TMJ).

*[(48)]* **Third-party examinations.]**

*[(49)](62)* Tobacco cessation—patches and gum are not covered. *[There is a limited benefit available under the pharmacy benefit.]*

**(63) Transplant benefits at a non-network facility. Non-network facility charges and payments for transplants are limited to the following maximum only:**

- (A) Allogenic Bone Marrow—\$143,000;
- (B) Autologous Bone Marrow—\$121,000;
- (C) Heart—\$128,000;
- (D) Heart and Lung—\$133,000;
- (E) Lung—\$151,000;
- (F) Kidney—\$54,000;
- (G) Kidney and Pancreas—\$97,000; and
- (H) Liver—\$153,000.

*[(50)]* **Transplants—double listing—payment only for one (1) evaluation up to time of actual transplant.]**

*[(51)](64)* Transplants—travel expense—requires authorization from medical plan. Limited to ten thousand dollar (\$10,000) maximum per transplant when accessing network services. **Travel expenses include travel and lodging allowance for recipient and his/her immediate family travel companion. When a participant is younger than nineteen (19) years of age, travel expenses are covered for both parents. Transplant facility must be more than one hundred (100) miles from the recipient's residence. Meals are not covered.**

*[(52)]* **Transsexual surgery—health services and associated expenses in the transformation operations regardless of any diagnosis or gender role disorientation or psychosexual orientation or any treatment or studies related to sex transformation. Also excludes hormonal support for sex transformation.]**

*[(53)](65)* Travel expenses—not covered *[unless authorized by claims administrator]* **except for transplants in a network facility.**

*[(54)](66)* Trimming of nails, corns, or calluses—not covered except for persons being treated for diabetes, peripheral vascular disease, or blindness.

*[(55)](67)* Usual, Customary, and Reasonable (UCR)—charges exceeding UCR are not covered, as applicable to the non-network benefit.

*[(56)](68)* Vitamins and nutrients—limited to prenatal agents for pregnancy, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents through the pharmacy benefit.

*[(57)]* **War or insurrection—liability to provide services limited in the event of a major disaster, epidemic, riot, or other circumstances beyond the control of the plan.]**

*[(58)](69)* Workers' compensation—charges for services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other **similar** legislation *[of similar program]*.

**AUTHORITY:** section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Amended: Filed Dec. 22, 2010.

**PUBLIC COST:** This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

**PRIVATE COST:** This proposed amendment will cost private entities twenty thousand three hundred eighty-seven dollars (\$20,387) in the aggregate.

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.



**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 3**

<b>Rule Number and Title:</b>	<b>22 CSR 10-3.060 PPO 600 Plan, PPO 1000 Plan, PPO 2000 and HDHP Limitations</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>1,411 individuals enrolled in MCHCP public entity plans for CY 2011</b>	<b>Individuals enrolled in MCHCP public entity plans for CY 2011</b>	<b>\$20,387</b>

**III. WORKSHEET**

Estimated cost is the annual cost for public entity subscribers' non-covered infertility services under the MCHCP medical plans for calendar year 2011.

**IV. ASSUMPTIONS**

- Estimated annual cost for infertility services is \$20,387;
- Other rule changes are clarifications and are not new limitations.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-3.075 Review and Appeals Procedure.** The Missouri Consolidated Health Care Plan is amending the rule purpose and all sections of this rule.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to review and appeals procedures for participation in, and coverage of services under, the Missouri Consolidated Health Care Plan.*

*PURPOSE: This rule establishes the policy of the board of trustees in regard to review and appeals procedures for participation in, and coverage of services under, the Missouri Consolidated Health Care Plan.*

*[(1) When any participant shall suffer any injury or sickness giving rise to claim under these rules, s/he shall have free choice of providers practicing legally in the location in which service is provided to the end that a provider/patient relationship shall be maintained. Reimbursement will be in accordance with the benefit provisions of the type of coverage chosen by the participant.*

*(2) The plan administrator, agent, or claims administrator, upon receipt of a notice of request, shall furnish to the employee the forms as are usually furnished for filing proofs of loss. If the forms are not furnished within thirty (30) days after the giving of such notice, the employee shall be deemed to have complied with the requirement as to proof of loss upon submitting, within the time fixed for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which request is made.*

*(3) Written proof of claims incurred should be furnished to the claims administrator as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the claims administrator before they are paid.*

*(4) In the case of medical benefits, the claims administrator will send written notice of any amount applied toward the deductible as well as any payments made. The claims administrator may also send a request for additional information or material to support the claim, along with reasons why this information is necessary.*

*(5) All members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the health plan contractor or claims administrator applicable to the member. Appeals to the health plan contractor or claims administrator must be made in writing within one hundred eighty (180) days of receiving the denial or notice which gave rights to the appeal. Only after these procedures have been exhausted may the member appeal directly to the Missouri Consolidated Health Care Plan to review the decision of the health plan contractor or claims administrator.*

*(A) Appeals to MCHCP shall be submitted in writing within forty-five (45) days of receiving the final decision from the member's health care plan contractor or claims administrator, specifically identifying the issue to be resolved.*

*Administrative appeals shall be submitted in writing as soon as possible following written or verbal notice of an MCHCP staff denial of the member's administrative request. All appeals and administrative appeals shall be addressed to:*

*Attn: Appeal  
Board of Trustees  
Missouri Consolidated Health Care Plan  
PO Box 104355  
Jefferson City, MO 65110*

*(B) The board may, in its discretion, choose to conduct a hearing regarding a member's appeal. If the board decides a hearing is needed to render a decision, it may utilize a hearing officer or committee to conduct a fact-finding hearing and make proposed findings of fact and conclusions of law. In such cases—*

- 1. The hearing will be scheduled by the MCHCP;*
- 2. The parties to the hearing will be the insured and the applicable health plan or MCHCP staff in self-insured situations;*
- 3. All parties shall be notified in writing of the date, time, and location of the hearing;*
- 4. All parties shall have the right to appear at the hearing and submit written or oral evidence. The appealing party shall be responsible for all copy charges incurred by MCHCP in connection with any documentation that must be obtained through the MCHCP. These fees will be reimbursed should the party prevail in his/her appeal. They may cross-examine witnesses. They need not appear and may still offer written evidence. The strict rules of evidence shall not apply;*
- 5. The party appealing to the board shall carry the burden of proof; and*
- 6. The hearing officer shall propose findings of fact and conclusions of law, along with its recommendation, to the board. Copies of the summary, findings, conclusions, and recommendations shall be sent to all parties.*

*(C) The board may, but is not required to, review the transcript of the hearing and solicit additional evidence and argument. It will review the summary of evidence and the proposed findings of fact and conclusions of law and shall then issue its final decision on the matter.*

- 1. All parties shall be given a written copy of the board's final decision.*
- 2. All parties shall be notified that if they feel aggrieved by the final decision, they shall have the right to seek judicial review of the decision as provided by Missouri law.*
- (D) Administrative decisions made solely by MCHCP may be appealed directly to the board of trustees, by either a member or health plan contractor providing a fully-insured product.*

- 1. All the provisions of this rule, where applicable, shall apply to these appeals.*
- 2. The parties to such appeal shall be the appellant and the MCHCP shall be respondent.*
- 3. The appellant, if aggrieved by the final decision of the board, shall have the right of appeal as stated in subsection (5)(C) herein.]*

**(1) Claims Submissions and Initial Benefit Determinations.**

*(A) Members shall use the claims and administration procedures established by the vendor administering the particular service for which coverage, authorization, or payment is sought.*

*(B) Medical and pharmacy service claims are divided into three (3) types: pre-service, post-service, and concurrent claims.*

*1. Pre-service claims are requests for approval that the plan or vendor requires a member to obtain before getting medical care or filling a prescription, such as prior authorization or a*

decision whether a treatment, procedure, or medication is medically necessary.

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than fifteen (15) days from the date the vendor receives the claim. The vendor may extend the time period up to an additional fifteen (15) days if, for reasons beyond the vendor's control, the decision cannot be made within the first fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

B. Urgent care claims are a special type of pre-service claim that require a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within seventy-two (72) hours. Written confirmation of the decision will be sent by the vendor as soon as possible thereafter.

2. Post-service claims are all other claims for services including claims after medical or pharmacy services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

A. Post-service claims must be decided within a reasonable period of time, but not later than thirty (30) days after the vendor receives the claim. If, because of reasons beyond the vendor's control, more time is needed to review the claim, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

3. Concurrent claims are claims related to an ongoing course of previously-approved treatment. If the plan or vendor has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. The plan or vendor will notify a member in writing prior to reducing or ending a previously-approved course of treatment in sufficient time to allow the member or the member's provider to appeal and obtain a determination before the benefit is reduced or terminated.

(C) Claims incurred should be furnished to the vendor by the provider or the member as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the vendor before they are paid.

(D) If a member, or a provider or authorized representative on behalf of a member, submits a request for coverage or a claim for services that is denied in whole or in part, the member will receive an initial denial notice within the time frames described in this rule that will include the following information:

1. The reasons for the denial;

2. Reference to the plan provision, regulation, statute, clinical criteria, or guideline on which the denial was based with information as to how the member can obtain a copy of the provision, regulation, statute, clinical criteria, or guideline free of charge;

3. A description of any documentation or information that is

necessary for the member to provide if documentation or information is missing and an explanation as to why the documentation or information is needed, if applicable; and

4. Information as to steps the member can take to submit an appeal of the denial.

(2) General Appeal Provisions.

(A) All individuals seeking review or appeal of a decision of the plan, plan administrator, claims administrator, or any vendor shall follow the procedures applicable to the type of decision appealed as set forth in this rule.

(B) All appeals must be submitted in writing to the appropriate reviewer as established in this rule by the member, the individual seeking review, or his/her authorized representative.

(C) Unless specifically provided otherwise in this rule, all appeals to the plan, plan administrator, claims administrator, or applicable vendor must be made, initiated in writing, within one hundred eighty (180) days of receiving the denial or notice which gave rights to the appeal.

(3) Appeal Process for Medical and Pharmacy Determinations.

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply.

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage once an individual has been covered under the plan, unless the individual, or a person seeking coverage on behalf of the individual, performs an act, practice, or omission that constitutes fraud, or unless such individual or person makes an intentional misrepresentation of material fact in connection with seeking coverage or any benefits under the plan.

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination.

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative.

4. External review. External review means a review of an adverse benefit determination (including a final internal adverse benefit determination) by the Missouri Department of Insurance, Financial Institutions and Professional Registration, Division of Consumer Affairs (DIFP) regarding covered medical and pharmacy benefits administered by plan vendors, UMR, Mercy Health Plans, or Express Scripts Inc., in accordance with state law and regulations promulgated by DIFP and made applicable to the plan by agreement and between the plan and DIFP pursuant to Technical Guidance from the U.S. Department of Health and Human Services dated September 23, 2010.

5. Final internal adverse benefit determination. A final

internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law.

6. Final external review decision. A final external review decision means a determination rendered under the DIFP external review process at the conclusion of an external review.

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect;

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

C. The termination or discontinuance of coverage is effective retroactively at the request of the member in accordance with applicable provisions of this chapter regarding voluntary cancellation of coverage.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review by DIFP.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level appeals shall be responded to in writing to the member within sixty (60) days for post-service claims and within thirty (30) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First level appeals must be submitted in writing to—

UMR Claims Appeal Unit  
PO Box 30546  
Salt Lake City, UT 84130-0546

(b) Second level appeals must be sent in writing to—

UMR Claims Appeal Unit  
PO Box 8086  
Wausau, WI 54402-8086

(c) Expedited appeals must be communicated by calling UMR telephone 1-866-868-7758 or by submitting a written fax to 1-866-912-8464, Attention: Appeals Unit.

(VI) For members with medical coverage through Mercy Health Plans—

(a) First and second level appeals must be submitted in writing to—

Mercy Health Plans  
Attn: Corporate Appeals  
14528 S. Outer 40 Road, Suite 300  
Chesterfield, MO 63017

(b) Expedited appeals must be communicated by calling Mercy Health Plans telephone 1-800-830-1918, ext. 2394 or by submitting a written fax to 1-314-214-3233, Attention: Corporate Appeals.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member claimant attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the claimant believes the claim should be paid, and any other written documentation to support the claimant's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts  
Clinical Appeals—MH3  
6625 West 78th Street, BL0390  
Bloomington, MN 55439  
or by fax to 1-877-852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(4) Except as otherwise expressly provided in this rule, appeals of adverse determinations made by MCHCP may be appealed to the board by fax or letter to the following address:

Attn: Appeal  
Board of Trustees  
Missouri Consolidated Health Care Plan  
PO Box 104355  
Jefferson City, MO 65110

[(6)](5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines:/.

(A) Newborns—If a member currently has coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within three (3) months of the child's date of birth.

(B) Agency error—MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office, the MCHCP, or plan offered by MCHCP that was no fault of the member.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year.

(D) Non-payment—MCHCP may allow one (1) reinstatement for terminations due to non-payment (per lifetime of account).

(E) Reinstatement before termination—MCHCP may reinstate coverage if request is received prior to end of current coverage.

(F) Termination dental and/or vision coverage—MCHCP may terminate dental and/or vision coverage if request is received prior to February 1 and if no claims have been made/paid for January.

(G) Proof of eligibility—MCHCP may approve late receipt of proof-of-eligibility documentation if MCHCP can verify that it took an unreasonable amount of time for the public entity (county or state) to provide subscriber with requested documentation.

(H) Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage.

(I) Loss of coverage notice—MCHCP may approve late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.

(J) *[Lifestyle Ladder]* Wellness Program participation—MCHCP may deny all appeals regarding continuation of participation in *[Lifestyle Ladder]* the Wellness Program due to failure of member's participation.

(K) Proof of open enrollment confirmation—MCHCP may approve appeals if subscriber is able to provide a confirmation sheet from open enrollment. However, such administrative appeals must be received by MCHCP on or before the last day of February.

(L) Substantiating evidence—MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period.

(M) New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Amended: Filed Dec. 22, 2008, effective June 30, 2009. Amended: Filed Feb. 17, 2010, effective Aug. 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, terminated Jan. 20, 2011. Emergency amendment filed Jan. 10, 2011, effective Jan. 20, 2011, expires June 29, 2011. Amended: Filed Jan. 10, 2011.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions twelve thousand five hundred dollars (\$12,500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Name:</b>	<b>22 CSR 10-3.075 Review and Appeals Procedure</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003</b>	<b>\$12,500</b>

**III. WORKSHEET**

Estimated cost is the annual cost for all public entity external review costs for calendar year 2011.

**IV. ASSUMPTIONS**

- Vendors are not charging an additional fee for the internal member appeal process.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-3.090 Pharmacy Benefit Summary.** The Missouri Consolidated Health Care Plan is amending the rule purpose and sections (1), (5), and (6), deleting section (3) and renumbering accordingly, and adding new sections (7) and (8).

*PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the Pharmacy Benefit Summary for the PPO 600 Plan, PPO 1000 Plan, and PPO 2000 Plan of the Missouri Consolidated Health Care Plan.*

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for [Copay Plan, PPO 300 Plan, PPO 500 Plan,] the PPO 600 Plan, PPO 1000 Plan, and PPO 2000 Plan of the Missouri Consolidated Health Care Plan.*

(1) The pharmacy benefit provides coverage for prescription drugs **listed on the formulary**, as described in the following:

(A) Medications.

1. **Retail—Network:**

A. Generic: Eight-dollar (\$8) copayment for up to a thirty (30)-day supply for generic drug on the formulary;

B. *[Formulary brand]* **Brand:** Thirty-five-dollar (\$35) copayment for up to a thirty (30)-day supply for brand drug on the formulary;

*[C. Non-formulary: Fifty-five dollar (\$55) copayment for up to a thirty (30)-day supply for non-formulary drug;*

*D. Prescriptions filled with a formulary brand drug when there is a Food and Drug Administration (FDA)-approved generic will be subject to the generic copayment amount in addition to paying the difference between the cost of the generic and the formulary brand drug;]*

*[E/C. Mail order program—*

(I) Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for *[two and one-half (2 ½) regular copayments]* **a twenty-dollar (\$20) copayment for a generic drug on the formulary or a eighty-seven-dollar-and-fifty-cent (\$87.50) copayment for a brand drug on the formulary.**

(II) Specialty drugs covered only through network mail order for up to thirty (30) days. Copayments~~[-]~~—

(a) Generic: *[six]* **eight dollars [and sixty-seven cents (\$6.67);]** **(\$8) for generic drug on the formulary list; and**

*[(b) Formulary brand: twenty-nine dollars and seventeen cents (\$29.17); and*

*(c) Non-formulary: forty-five dollars and eighty-three cents (\$45.83).]*

**(b) Brand: thirty-five dollars (\$35) for brand drug on the formulary.**

2. Non-network pharmacies—If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable copayment **or coinsurance**. All such claims must be filed within twelve (12) months of the incurred expense.

3. Retail prescription drugs—Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

*[(3) Retail and mail order coverage includes the following (except for specialty drugs):*

*(A) Diabetic supplies, including:*

- 1. Insulin;*
- 2. Syringes;*
- 3. Test strips;*
- 4. Lancets; and*
- 5. Glucometers;*

*(B) Prescribed vitamins, excluding those vitamins that may be purchased over-the-counter;*

*(C) Prescribed self-injectables;*

*(D) Oral chemotherapy agents;*

*(E) Hematopoietic stimulants;*

*(F) Growth hormones with prior authorization;*

*(G) Infertility drugs—subject to fifty percent (50%) member coinsurance; and*

*(H) Tobacco cessation prescriptions—subject to formulary restrictions and limited to five hundred dollar (\$500) annual benefit.]*

*[(4)](3) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first step drug, the physician may request a prior authorization from the pharmacy plan administrator. If the prior authorization is approved, the member is responsible for the applicable copayment which may be higher than the first step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.*

*(A) First Step—*

- 1. Uses primarily generic drugs;*
- 2. Lowest applicable copayment is charged; and*
- 3. First step drugs must be used before the plan will authorize payment for second step drugs.*

*(B) Second Step—*

- 1. This step applies if the member's treatment plan requires a different medication after attempting the first step medication;*
- 2. Uses primarily brand-name drugs; and*
- 3. Typically, a higher copayment amount is applicable.*

*[(5)](4) Prior Authorization—Certain medications are subject to prior authorization. Network pharmacies will notify the member if prior authorization is required. The member or the pharmacy must contact the pharmacy plan administrator before payment will be approved.*

*[(6)](5) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy plan administrator. In order to file a claim, members must—*

*(A) Complete the claim form; and*

*(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions, except diabetic supplies. If attaching a receipt or label, the receipt or label shall include~~[-]~~:*

- 1. Pharmacy name and address;*
- 2. Patient's name;*
- 3. Price;*
- 4. Date filled;*
- 5. Drug name, strength, and national drug code (NDC);*
- 6. Prescription number;*
- 7. Quantity; and*
- 8. Days' supply.*

*[(7)](6)* Formulary—The formulary *[does not change during a calendar year, unless]* is updated on a semi-annual basis, or when—

(A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; or

(B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit; *[and]* or

(C) A drug is determined to have a safety issue.

(7) Limitation—Prescription drugs not listed on the formulary are not a covered benefit except for prescription drugs that have been grandfathered for members who have taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011. If the participant purchased a brand-name drug that is grandfathered when there is a Food and Drug Administration (FDA)-approved generic drug, the participant shall pay the generic copayment plus the difference in the brand and generic cost of the drug. Grandfathered drugs include:

(A) Alzheimer's disease drugs;

(B) Antidepressants, including selective serotonin reuptake inhibitors (SSRIs) and selective serotonin and norepinephrine reuptake inhibitors (SNRIs);

(C) Anti-epileptics;

(D) Biologics for inflammatory conditions;

(E) Cancer drugs;

(F) Hemophilia drugs (Factor VIII and IX concentrates);

(G) Hepatitis drugs;

(H) Immunosuppressants (transplant anti-rejection agents);

(I) Insulin (basal);

(J) Low molecular weight heparins;

(K) Multiple sclerosis injectable drugs;

(L) Novel psychotropics (oral products and long-active injectables);

(M) Phosphate binders;

(N) Pulmonary hypertension drugs; and

(O) Somatostatin analogs.

(8) Under the High Deductible Health Plan (HDHP), pharmacy benefits are subject to the applicable medical plan deductible and coinsurance.

*AUTHORITY:* section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Amended: Filed Dec. 22, 2010.

*PUBLIC COST:* This proposed amendment will cost state agencies or political subdivisions nine hundred five thousand, eight hundred seventeen dollars (\$905,817) in the aggregate.

*PRIVATE COST:* This proposed amendment will cost private entities nine hundred five thousand, eight hundred seventeen dollars (\$905,817) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.



**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 3**

<b>Rule Number and Name:</b>	<b>22 CSR 10-3.090 Pharmacy Benefit Summary</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003</b>	<b>\$905,817</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the public entities premium for providing pharmacy benefits to all public entity employees who enrolled for coverage under an MCHCP plan for calendar year 2011.

**IV. ASSUMPTIONS**

- Total enrollment under MCHCP Plans as of January 1, 2011 (data used the CY2011 projection);
- Calendar year 2011 membership in all MCHCP Plans remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Actual costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Title:</b>	<b>22 CSR 10-3.090 Pharmacy Benefit Summary</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>1,411 individuals enrolled in MCHCP public entity plans for CY 2011</b>	<b>Individuals enrolled in MCHCP public entity plans for CY 2011</b>	<b>\$905,817</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent for all public entity subscribers' premium costs for pharmacy coverage for calendar year 2011. In addition, members will pay the following copayments based upon their individual utilization of covered benefits:

- \$8 copayment for up to a 30-day supply of generic medication obtained at retail pharmacy
- \$35 copayment for up to a 30-day supply of formulary medication obtained at retail pharmacy
- \$20 copayment for up to a 90-day supply of generic medication obtained at mail order pharmacy
- \$87.50 copayment for up to a 90-day supply of formulary medication obtained at mail order pharmacy

**IV. ASSUMPTIONS**

- Total enrollment in the MCHCP pharmacy plan as of January 1, 2011 (data used for the CY2011 projection);
- Calendar year 2011 membership in the MCHCP pharmacy plan remains relatively stable;
- Calendar year 2011 rates based on projections of self-insured premiums as developed by MCHCP's actuary.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED RULE**

**22 CSR 10-3.092 Dental Benefit Summary**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the Dental Benefit Summary for members of the Missouri Consolidated Health Care Plan.*

(1) Two (2) dental benefit packages are available for a public entity to choose from—basic and high.

(A) The basic benefit package provides coverage for—

1. Coverage A—diagnostic and preventive services;
2. Coverage B—basic and restorative services; and
3. Coverage C—major services.

(B) The high benefit package provides coverage for—

1. Coverage A—diagnostic and preventive services;
2. Coverage B—basic and restorative services;
3. Coverage C—major services; and
4. Coverage D—orthodontic services for children younger than

nineteen (19).

(2) Procedures for Using the Dental Plan. A member may visit the dentist of his/her choice and select any dentist on a treatment-by-treatment basis. Members may go to a participating or non-participating network dentist. If a member goes to a non-participating network dentist, the dental plan will make payment directly to the member on the lesser of the dentist billed charge or the applicable maximum plan allowance.

(3) Dental benefits, deductibles, and coinsurance include:

<b>DENTAL SERVICES</b>			
	<b>BASIC</b>	<b>HIGH</b>	
<b>Coverage A – Diagnostic &amp; Preventive</b>	<b>You Pay</b>	<b>You Pay</b>	<b>Note</b>
Examinations Prophylaxis (teeth cleaning) Fluoride X-rays Emergency Palliative Treatment Space Maintainers Sealants	No deductible 0% coinsurance	No deductible 0% coinsurance	Dental exams, X-rays, cleanings and fluoride treatment do not apply to the individual plan maximum
<b>Coverage B – Basic &amp; Restorative</b>	<b>You Pay</b>	<b>You Pay</b>	<b>Note</b>
Minor Restorative Services (fillings) Oral surgery, including extractions Periodontics Endodontics	\$50/person deductible* 20% coinsurance	\$50/person deductible* 20% coinsurance	
<b>Coverage C – Major Services</b>	<b>You Pay</b>	<b>You Pay</b>	<b>Note</b>
Prosthodontics (bridges, dentures) Major Restorative Services (crowns, inlays, onlays, labial veneers)	\$50/person deductible* 50% coinsurance	\$50/person deductible* 50% coinsurance	12-month waiting period applies to replacement prosthetic devices. The waiting period is waived with proof of 12-month continuous dental coverage for major services immediately prior to the effective date of coverage in MCHCP's dental plan
<b>Coverage D – Orthodontic Services for children younger than 19</b>	<b>You Pay</b>	<b>You Pay</b>	<b>Note</b>
Treatment for correction of malposed teeth to establish proper occlusion through movement of teeth or their maintenance in position	Orthodontia is not covered	\$50/child deductible* 50% coinsurance	Orthodontic lifetime maximum of \$1,000 per dependent child younger than 19
<i>Coverage is limited to \$1,000 per person per calendar year benefit period.</i> <i>*Coinsurance amounts apply after the \$50 individual deductible is met under Coverage B, C or D, or combined.</i>			

(4) Alternative Treatment. If alternative treatment plans are available, this dental plan will be liable for the least costly, professionally satisfactory course of treatment. This includes, but is not limited to, services such as composite resin fillings on molar teeth, in which case the benefits are based on the cost of the amalgam (silver) filling. This also includes fixed bridges, in which case the benefits will be based on the cost of a removable partial denture.

(5) Transferring Care. If participant receives care from more than one (1) dentist or service provider for the same procedure, benefits will not exceed what would have been paid for one (1) dentist for that procedure (including, but not limited to, prosthetic devices and root canal therapy).

(6) Claim Pre-Determination. If the care member needs costs less than two hundred dollars (\$200) or is emergency care, member's dentist will proceed with treatment at member's option. If the cost estimate is more than two hundred dollars (\$200) and is not emergency care, member's dentist will determine what treatment member needs and could submit a treatment plan to dental plan for a pre-determination of benefits. This estimate will enable the member to determine in advance how much of the cost will be paid by his/her dental coverage and how much he/she will be responsible for paying.

(7) Claim Filing Deadline. Member's claims must be filed by the end of the calendar year after the year in which services were rendered. The dental plan is not obligated to pay claims submitted after this period. If a claim is denied due to a participating dentist's failure to make timely submission, participant will not be liable to such dentist for the amount that would have been payable by the dental plan, provided that member advised the dentist of participant's eligibility for benefits at the time of treatment.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Original rule filed Dec. 22, 2010.*

*PUBLIC COST: This proposed rule will cost state agencies or political subdivisions one hundred fourteen thousand, four hundred nineteen dollars (\$114,419) in the aggregate.*

*PRIVATE COST: This proposed rule will cost private entities one hundred fourteen thousand, four hundred nineteen dollars (\$114,419) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Name:</b>	<b>22 CSR 10-3.092 Dental Benefit Summary</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003</b>	<b>\$114,419</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the public entity premium for public entity employees who enrolled for coverage under this plan for calendar year 2011.

**IV. ASSUMPTIONS**

- Total enrollment under the all public entity plans as of December 10, 2010;
- Calendar year 2011 membership in the public entity dental plans remain relatively stable;
- Calendar year 2011 rates based on projections of fully-insured premiums as developed by as developed by Delta Dental;
- Calculations are based on Active Employee Only premiums and do not include dependents or retirees;
- Calculations are based on average premiums for all public entities;
- Calculations assume each public entity enrolled in the dental plan is contributing at least 50 percent toward the employee only monthly premium;
- Actual costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 – Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 3**

<b>Rule Number and Title:</b>	<b>22 CSR 10-3.092 Dental Benefit Summary</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>676 individuals enrolled in MCHCP Public Entity Dental Plan for CY 2011</b>	<b>Individuals enrolled in the MCHCP Public Entity Dental Plan for CY 2011</b>	<b>\$114,419</b>

**III. WORKSHEET**

Estimated cost is the annual cost for public entity subscribers' premium costs for dental coverage for calendar year 2011. The public entity must contribute at least fifty percent toward the employee only month premium for the dental plan. Dental coverage is limited to a \$1,000 per person calendar year benefit. In addition, members will pay the following deductible and coinsurance based upon their individual utilization of covered benefits:

**Basic Plan**

- \$50 annual deductible per person and 20% coinsurance for Coverage B – Basic & Restorative
  - Coinsurance amounts apply after the \$50 individual deductible is met under either Coverage B or C, or combined
- \$50 annual deductible per person and 50% coinsurance for Coverage C – Major Services
  - Coinsurance amounts apply after the \$50 individual deductible is met under either Coverage B or C, or combined

**High Plan**

- \$50 annual deductible per person and 20% coinsurance for Coverage B – Basic & Restorative

- Coinsurance amounts apply after the \$50 individual deductible is met under either Coverage B,C or D, or combined
- \$50 annual deductible per person and 50% coinsurance for Coverage C – Major Services
  - Coinsurance amounts apply after the \$50 individual deductible is met under either Coverage B, C or D, or combined
- \$50 annual deductible per person and 50% coinsurance for Coverage D – Orthodontic Services
  - Coinsurance amounts apply after the \$50 individual deductible is met under either Coverage B, C or D, or combined
  - Orthodontic lifetime maximum of \$1000 per dependent child younger than age 19

#### **IV. ASSUMPTIONS**

- Total enrollment in the public entity dental plans as of December 10, 2010 (data used for the CY2011 projection);
- Calendar year 2011 membership in the public entity dental plans remains relatively stable;
- Calendar year 2011 rates based on projections of fully-insured premiums as developed by Delta Dental;
- Calculations assume each public entity enrolled in the dental plan is contributing at least 50 percent toward the employee only monthly premium;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.



**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED RULE**

**22 CSR 10-3.093 Vision Benefit Summary**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the vision benefit summary for members of the Missouri Consolidated Health Care Plan.*

(1) Vision Plan. The vision benefit provides coverage of refractive care exams, eyeglass lenses and frames, contact lenses, and corrective laser surgeries.

(2) Vision benefits and copayments include:

VISION SERVICES		
BENEFITS	NETWORK	NON-NETWORK
<b>Exams – once every 12 months</b>		
<b>Vision Exam</b>	\$10 copayment	Reimbursed up to \$36
<b>Lenses – once every 12 months – one \$25 copayment for lenses and frames when purchased together</b>		
<b>Single vision lenses (per pair)</b>	\$25 copayment	Reimbursed up to \$28
<b>Bifocal lenses (per pair)</b>	\$25 copayment	Reimbursed up to \$45
<b>Trifocal lenses (per pair)</b>	\$25 copayment	Reimbursed up to \$56
<b>Lenticular lenses (per pair)</b>	\$25 copayment	Reimbursed up to \$80
<b>Polycarbonate lenses (per pair)</b> Applies to dependent children only	\$25 copayment	Not covered
<b>Frames – once every 24 months – one \$25 copayment for lenses and frames when purchased together</b>		
<b>Frames</b>	\$25 copayment Up to \$120 plus 20% discount on any out-of-pocket costs	Reimbursed up to \$45
<b>Contact Lenses – once every 12 months in place of eye glass lenses</b>		
<b>Elective</b> If member prefers contacts to glasses	\$10 copayment for exam Up to \$125 for contact lenses and contact lens exam (fitting and evaluation) 15% discount on the cost of contact lens exam (fitting and evaluation)	Reimbursed up to \$36 for exam Contact lenses, evaluation, design and fitting reimbursed up to \$105
<b>Necessary</b> If medically necessary with prior approval from VSP	\$10 copayment for exam Additional costs covered at 100%	Reimbursed up to \$36 for exam Contact lenses, evaluation, design and fitting reimbursed up to \$210
<b>Corrective Laser Surgery – contact your provider, or contact VSP at 888-354-4434 for more information</b>		

<b>PRK</b>	Maximum amount you pay: \$1,500 per eye	Not covered
<b>LASIK</b>	Maximum amount you pay: \$1,800 per eye	Not covered
<b>Custom LASIK</b>	Maximum amount you pay: \$2,300 per eye	Not covered
<b>Other</b>		
<b>Optional Items (cosmetic extras)</b>	Not covered	Not covered

(3) Value-Added Discount Program. A member can receive a twenty-percent (20%) discount on additional glasses and sunglasses, including lens options from any network provider, within twelve (12) months of participant's last eye exam.

(4) Soft Contact Lenses. A member who wears soft contact lenses will qualify for a special contact lens program. The program covers—

- (A) A contact lens exam;
- (B) Six (6)-month supply of contacts from the specific list of contact lens products and manufacturers; and
- (C) Two (2) follow-up visits.
- (D) A member who requires premium services when being fitted for contact lenses will not qualify for the contact lens care program. The member's provider will determine if the member qualifies for a standard fit or a premium fit based on the guidelines of—
  - 1. Standard fit contact lens patients—
    - A. Typically the member does not require additional time for care, training, or problem solving; and
    - B. Typically the member can be successfully fitted in up to two (2) follow-up visits; and
  - 2. Premium fit contact lens patients—
    - A. Typically the member will require additional time for care, training, or problem solving; and
    - B. Typically the member cannot be successfully fitted in up to two (2) follow-up visits.
- (E) The member will be responsible for the cost above the allowed network or non-network contact lens benefit. Contact lens care program products, manufacturers, replacement fees, and refit fees are as follows:

Tier One: Spherical				
Product	Manufacturer	Boxes Covered	Replacement Wearers	Refit Wearers
ACUVUE	Vistakon	4	\$130	\$170
ACUVUE 2	Vistakon	4		
AIR OPTIX AQUA	CIBA Vision	2		
Biofinity	CooperVision	2		
Biomedics 55 Premier	CooperVision	4		
Biomedics 55 UV	CooperVision	4		
Biomedics XC	CooperVision	4		
Focus Monthly Visitint (Focus Visitint)	CIBA Vision	2		
Frequency 38	CooperVision	2		
Frequency 55 Aspheric	CooperVision	2		
Frequency 55 Sphere	CooperVision	2		
FreshLook Handling Tint	CIBA Vision	4		
O2OPTIX	CIBA Vision	2		
Proclear Sphere (Compatibles)	CooperVision	2		
PureVision	Bausch & Lomb	2		
SofLens 39 (Optima FW, Sequence II)	Bausch & Lomb	4		
Vertex Sphere (Encore Sphere)	CooperVision	4		

Tier Two: Spherical				
Product	Manufacturer	Initial Supply Boxes	Replacement Wearers	Refit Wearers
ACUVUE ADVANCE	Vistakon	4	\$160	\$190
ACUVUE OASYS with HYDRACLEAR PLUS	Vistakon	4		
AIR OPTIX NIGHT & DAY AQUA	CIBA Vision	2		
Avaira	CooperVision	4		
Biomedics 38	CooperVision	4		
Extreme H <sub>2</sub> O 59% - Thin	Hydrogel	4		
Extreme H <sub>2</sub> O 59% - Xtra	Hydrogel	4		
Extreme H <sub>2</sub> O 54%	Hydrogel	4		
Focus 1-2 Week Visitint (NewVues Visitint)	CIBA Vision	4		
PRECISION UV	CIBA Vision	4		

<b>Tier Three: Specialty Lenses</b>				
<b>Product</b>	<b>Manufacturer</b>	<b>Initial Supply Boxes</b>	<b>Replacement Wearers</b>	<b>Refit Wearers</b>
<b>ACUVUE ADVANCE <i>for ASTIGMATISM</i></b>	<b>Vistakon</b>	<b>4</b>	<b>\$180</b>	<b>\$210</b>
<b>ACUVUE OASYS <i>for ASTIGMATISM</i></b>	<b>Vistakon</b>	<b>4</b>		
<b>AIR OPTIX <i>for ASTIGMATISM</i></b>	<b>CIBA Vision</b>	<b>2</b>		
<b>Biofinity Toric</b>	<b>CooperVision</b>	<b>2</b>		
<b>Focus Monthly Toric Visiint (Focus Toric)</b>	<b>CIBA Vision</b>	<b>2</b>		
<b>Frequency 55 Multifocal</b>	<b>CooperVision</b>	<b>2</b>		
<b>Frequency 55 Toric</b>	<b>CooperVision</b>	<b>2</b>		
<b>Proclear EP Multifocal</b>	<b>CooperVision</b>	<b>4</b>		
<b>PureVision Multifocal</b>	<b>Bausch &amp; Lomb</b>	<b>2</b>		
<b>PureVision Toric</b>	<b>Bausch &amp; Lomb</b>	<b>2</b>		
<b>SofLens Toric</b>	<b>Bausch &amp; Lomb</b>	<b>4</b>		

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. Original rule filed Dec. 22, 2010.*

*PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed rule will cost private entities one hundred eighteen thousand, seven hundred forty dollars (\$118,740) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 – Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Title:</b>	<b>22 CSR 10-3.093 Vision Benefit Summary</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>1,145 individuals enrolled in MCHCP Public Entity Vision Plan for CY 2011</b>	<b>Individuals enrolled in the MCHCP Public Entity Vision Plan for CY 2011</b>	<b>\$118,740</b>

**III. WORKSHEET**

Estimated cost is the annual cost for public entity subscribers' premium costs for the vision plan for calendar year 2011. In addition, member payment will depend upon their individual utilization of covered benefits and following the payment schedule:

**In- network**

- \$20 copayment for vision exam
- \$25 copayment for single vision, bifocal, trifocal, lenticular and polycarbonate lenses
- \$25 copayment for frames
- \$25 copayment for lenses and frames when purchased together
- \$25 copayment and reimbursement up to \$120 for frames
- \$20 copayment for vision exam with reimbursed up to \$125 for contact lenses and contact lens exam for elective lenses
- \$20 copayment for vision exam with additional costs covered at 100% for medically necessary contact lenses
- \$1,500 maximum amount member pays for PRK Corrective Laser Surgery per eye
- \$1,800 maximum amount member pays for LASIK Corrective Laser Surgery per eye

- \$2,300 maximum amount member pays for Custom LASIK Corrective Laser Surgery per eye

**Non Network**

- Reimbursed up to \$36 for vision exam
- Reimbursed up to \$28 for single vision lenses
- Reimbursed up to \$45 for bifocal lenses
- Reimbursed up to \$56 for trifocal lenses
- Reimbursed up to \$80 for lenticular lenses
- Reimbursed up to \$45 for frames
- Reimbursed up to \$36 for vision exam and elective contact lenses, evaluation, design and fitting reimbursed up to \$105
- Reimbursed up to \$36 for vision exam and medical necessary contact lenses, evaluation, design and fitting reimbursed up to \$210

**IV. ASSUMPTIONS**

- Total enrollment in the public entity vision plan as of December 10, 2010 (data used for the CY2011 projection);
- Calendar year 2011 membership in the public entity vision plan remains relatively stable;
- Calendar year 2011 rates based on projections of fully-insured premiums as developed by Vision Service Plan;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**T**his section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order of rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted which has been changed from that contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

**T**he agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The ninety (90)-day period during which an agency shall file its order of rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the proposed rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

**Title 1—OFFICE OF ADMINISTRATION  
Division 50—Missouri Ethics Commission  
Chapter 3—Late Fee**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Ethics Commission under section 105.955.14(8), RSMo Supp. 2010, the commission amends a rule as follows:

**1 CSR 50-3.010 Late Fee is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 1, 2010 (35 MoReg 1400). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 12—DEPARTMENT OF REVENUE  
Division 10—Director of Revenue  
Chapter 44—Miscellaneous Fees and Taxes**

**ORDER OF RULEMAKING**

By the authority vested in the director of revenue under section 302.341.2, RSMo Supp. 2010, the director adopts a rule as follows:

**12 CSR 10-44.100 Excess Traffic Violation Revenue is adopted.**

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on November 1, 2010 (35 MoReg 1554–1555). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 13—DEPARTMENT OF SOCIAL SERVICES  
Division 40—Family Support Division  
Chapter 91—Rehabilitation Services for the Blind (RSB)**

**ORDER OF RULEMAKING**

By the authority vested in the Family Support Division under sections 167.195 and 192.935, RSMo Supp. 2010, the director amends a rule as follows:

**13 CSR 40-91.040 Payments for Vision Examinations is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 15, 2010 (35 MoReg 1482–1485). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 15—ELECTED OFFICIALS  
Division 30—Secretary of State  
Chapter 50—General**

**ORDER OF RULEMAKING**

By the authority vested in the commissioner of securities under section 409.6-605, RSMo Supp. 2010, the commissioner amends a rule as follows:

**15 CSR 30-50.010 Definitions is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 15, 2010 (35 MoReg 1479–1480). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Secretary of State, Securities Division received no comments.

**Title 15—ELECTED OFFICIALS  
Division 30—Secretary of State  
Chapter 51—Broker-Dealers, Agents, Investment  
Advisers, and Investment Adviser Representatives**

**ORDER OF RULEMAKING**

By the authority vested in the commissioner of securities under section 409.6-605, RSMo Supp. 2010, the commissioner amends a rule as follows:



**15 CSR 30-51.020 Applications for Registration or Notice Filings  
is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 15, 2010 (35 MoReg 1480-1481). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Secretary of State, Securities Division received no comments.

**Title 15—ELECTED OFFICIALS  
Division 30—Secretary of State  
Chapter 51—Broker-Dealers, Agents, Investment  
Advisers, and Investment Adviser Representatives**

**ORDER OF RULEMAKING**

By the authority vested in the commissioner of securities under section 409.6-605, RSMo Supp. 2010, the commissioner amends a rule as follows:

**15 CSR 30-51.030 Examination Requirement is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 15, 2010 (35 MoReg 1481). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Secretary of State, Securities Division received no comments.

**Title 15—ELECTED OFFICIALS  
Division 30—Secretary of State  
Chapter 51—Broker-Dealers, Agents, Investment  
Advisers, and Investment Adviser Representatives**

**ORDER OF RULEMAKING**

By the authority vested in the commissioner of securities under section 409.6-605, RSMo Supp. 2010, the commissioner amends a rule as follows:

**15 CSR 30-51.173 Supervision Guidelines for Investment  
Advisers is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 15, 2010 (35 MoReg 1482). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Secretary of State, Securities Division received no comments.

**T**his section may contain notice of hearings, correction notices, public information notices, rule action notices, statements of actual costs, and other items required to be published in the *Missouri Register* by law.

**Title 3—DEPARTMENT OF CONSERVATION  
Division 10—Conservation Commission  
Chapter 7—Wildlife Code: Hunting: Seasons, Methods,  
Limits**

**IN ADDITION**

**3 CSR 10-7.455 Turkeys: Seasons, Methods, Limits**

As a matter of public information, the following dates and bag limits shall apply to turkey hunting seasons for 2011. These are based on the formula for season dates set out in subsections (1)(A), (1)(B), and (1)(D) of this rule in the *Code of State Regulations*, and actions of the Conservation Commission on December 17, 2010, to annually establish the season length and bag limit of the spring, fall, and youth hunting seasons.

**Spring Season:** The 2011 spring turkey hunting season will be twenty-one (21) days in length (April 18–May 8, 2011). A person possessing the prescribed turkey hunting permit may take two (2) male turkeys or turkeys with a visible beard during the season; provided, only one (1) turkey may be taken the first seven (7) days of the season (April 18–April 24, 2011) and only one (1) turkey may be taken per day from April 25–May 8, 2011. Shooting hours: one-half (1/2) hour before sunrise to 1:00 p.m. Central Daylight Saving Time.

**Youth Spring Season Dates:** April 9–10, 2011. A youth possessing the prescribed youth turkey hunting permit and is at least six (6) but not older than fifteen (15) years of age may take one (1) male turkey or turkey with visible beard. Shooting hours: one-half (1/2) hour before sunrise to sunset, Central Daylight Saving Time.

**Fall Season:** The 2011 fall turkey hunting season will be thirty-one (31) days in length (October 1–October 31, 2011). Two (2) turkeys of either sex may be taken during the season. Shooting hours: one-half (1/2) hour before sunrise to sunset, Central Daylight Saving Time.

**Title 10—DEPARTMENT OF NATURAL RESOURCES  
Division 10—Air Conservation Commission  
Chapter 6—Air Quality Standards, Definitions, Sampling  
and Reference Methods and Air Pollution Control  
Regulations for the Entire State of Missouri**

**IN ADDITION**

**10 CSR 10-6.060 Construction Permits Required**

A notice of emergency rulemaking for 10 CSR 10-6.060 was published in the January 18, 2011, issue of the *Missouri Register* (36 MoReg 218–219). In the emergency statement and in the authority section, there was a typographical error. The expiration date of the emergency amendment was listed as July 2, 2011, when it should have been listed as July 1, 2011. The correct expiration date did appear in the emergency table on page 256 of the same issue. The corrected emergency statement and authority section appear below.

**EMERGENCY STATEMENT:** *The Department of Natural Resources finds that this emergency amendment is necessary to preserve a compelling governmental interest and to preserve the state's welfare by minimizing the impact of federal regulations. This rulemaking is necessary due to actions by the U.S. Environmental Protection Agency (EPA) related to the Greenhouse Gas Tailoring Rule, which was published June 3, 2010 (75 Federal Register 31514), and is effective August 2, 2010, which requires air permits for certain sources that emit greenhouse gases (GHGs). EPA states that without the Tailoring Rule, federal Prevention of Significant Deterioration (PSD) and title V requirements would apply as of January 2, 2011, for GHG pollutants at the one hundred (100)- and two hundred fifty (250)-tons-per-year levels provided under the Clean Air Act. This would greatly increase the number of required permits, impose undue costs on small sources, and overwhelm the resources of permitting authorities, including the Department of Natural Resources. EPA estimates that nationwide, without the Tailoring Rule, there would be eighty-two thousand (82,000) PSD permitting actions per year, compared to only one thousand six hundred (1,600) permitting actions per year with the Tailoring Rule, at an average cost ranging from fifty-nine thousand dollars (\$59,000) to eighty-four thousand five hundred dollars (\$84,500) per permit. EPA estimates that permitting authorities spend anywhere from two hundred ten (210) to three hundred one (301) hours to issue a PSD permit. The Tailoring Rule, which this emergency rulemaking is designed to implement, adopts a phased approach that raises the threshold for permitting to seventy-five thousand (75,000) or one hundred thousand (100,000) tons per year for GHG emissions. Rule 10 CSR 10-6.060 is being amended to incorporate permitting requirements that will cover new construction projects that emit GHG emissions of at least one hundred thousand (100,000) tons per year or modifications at existing facilities that increase GHG emissions by at least seventy-five thousand (75,000) tons per year. Without changes to this rule, EPA would have authority to issue air permits to Missouri sources for GHG emissions, resulting in the regulated industries having to work with an additional government agency and may result in a delay in permit issuance and increase cost. EPA does not have a regulatory requirement to issue permits in a timely manner, unlike the state, which is required to issue a PSD permit within one hundred eighty-four (184) days of a complete application. This amendment will ensure that the state maintains full authority over its permitting program and will avoid the need for the EPA to exercise its oversight authority to require states to meet minimum federal standards and to issue a State Implementation Plan (SIP) call, with a finding of failure to implement PSD and title V permit programs, for Missouri. EPA has authority under section 110 of the Clean Air Act to impose highway and emission offset sanctions if a state does not submit the required SIP revision or rescind a state's permitting authority.*

*As a result, the Department of Natural Resources finds that there is a compelling governmental interest that requires this emergency action. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the Missouri and United States Constitutions. The Department of Natural Resources believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed December 15, 2010, becomes effective January 3, 2011, and expires July 1, 2011. A proposed amendment covering this same material is published in the January 3, 2011, issue of the Missouri Register (35 MoReg 86).*

**AUTHORITY:** *section 643.050, RSMo 2000. Original rule filed Dec. 10, 1979, effective April 11, 1980. For intervening history, please consult the Code of State Regulations. Amended: Filed Nov. 30, 2010. Emergency amendment filed Dec. 15, 2010, effective Jan. 3, 2011, expires July 1, 2011.*

**Title 10—DEPARTMENT OF NATURAL RESOURCES  
Division 10—Air Conservation Commission  
Chapter 6—Air Quality Standards, Definitions, Sampling  
and Reference Methods and Air Pollution Control  
Regulations for the Entire State of Missouri**

**IN ADDITION**

**10 CSR 10-6.065 Operating Permits**

A notice of emergency rulemaking for 10 CSR 10-6.065 was published in the January 18, 2011, issue of the *Missouri Register* (36 MoReg 219-220). In the emergency statement and in the authority section, there was a typographical error. The expiration date of the emergency amendment was listed as July 2, 2011, when it should have been listed as July 1, 2011. The correct expiration date did appear in the emergency table on page 256 of the same issue. The corrected emergency statement and authority section appear below.

**EMERGENCY STATEMENT:** *The Department of Natural Resources finds that this emergency amendment is necessary to preserve a compelling governmental interest and to preserve the state's welfare by minimizing the impact of federal regulations. This rulemaking is necessary due to actions by the U.S. Environmental Protection Agency (EPA) related to the Greenhouse Gas Tailoring Rule, which was published June 3, 2010 (75 Federal Register 31514), and is effective August 2, 2010, which requires air permits for certain sources that emit greenhouse gases (GHGs). EPA states that without the Tailoring Rule, federal Prevention of Significant Deterioration (PSD) and title V requirements would apply as of January 2, 2011, for GHG pollutants at the one hundred (100)- and two hundred fifty (250)-tons-per-year levels provided under the Clean Air Act. This would greatly increase the number of required permits, impose undue costs on small sources, and overwhelm the resources of permitting authorities, including the Department of Natural Resources. EPA estimates that nationwide, without the Tailoring Rule, there would be six (6) million sources that would need title V operating permits, compared to only fifteen thousand five hundred (15,500) sources with the Tailoring Rule, at an average cost ranging from twenty-three thousand two hundred dollars (\$23,200) to forty-six thousand four hundred dollars (\$46,400) per permit. EPA estimates that permitting authorities spend anywhere from two hundred fourteen (214) to four hundred twenty-eight (428) hours to issue a title V permit. The Tailoring Rule, which this emergency rulemaking is designed to implement, adopts a phased approach that raises the threshold for permitting to seventy-five thousand (75,000) or one hundred thousand (100,000) tons per year for GHG emissions. Rule 10 CSR 10-6.065 is being amended to incorporate permitting requirements that will cover new construction projects that emit greenhouse gas (GHG) emissions of at least one hundred thousand (100,000) tons per year or modifications at existing facilities that increase GHG emissions by at least seventy-five thousand (75,000) tons per year. Without changes to this rule, EPA would have authority to issue air permits to Missouri sources for GHG emissions, resulting in the regulated industries having to work with an additional government agency and may result in a delay in permit issuance and increase cost. This amendment will ensure that the state maintains full authority over its permitting program and will avoid the need for the EPA to exercise its oversight authority to require states to meet minimum federal standards and to issue a State Implementation Plan (SIP) call, with a finding of failure to implement PSD and title V permit programs, for Missouri. EPA has authority under section 110 of the Clean Air Act to impose highway and emission offset sanctions if a state does not submit the required SIP revision or rescind a state's permitting authority.*

*As a result, the Department of Natural Resources finds that there is a compelling governmental interest that requires this emergency action. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections*

*extended in the Missouri and United States Constitutions. The Department of Natural Resources believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed December 15, 2010, becomes effective January 3, 2011, and expires July 1, 2011. A proposed amendment covering this same material is published in the January 3, 2011, issue of the Missouri Register (35 MoReg 95-96).*

**AUTHORITY:** *section 643.050, RSMo 2000. Original rule filed Sept. 2, 1993, effective May 9, 1994. For intervening history, please consult the Code of State Regulations. Amended: Filed Nov. 30, 2010. Emergency amendment filed Dec. 15, 2010, effective Jan. 3, 2011, expires July 1, 2011.*

**Title 19—DEPARTMENT OF HEALTH AND  
SENIOR SERVICES  
Division 60—Missouri Health Facilities Review  
Committee  
Chapter 50—Certificate of Need Program**

**NOTIFICATION OF REVIEW:  
APPLICATION REVIEW SCHEDULE**

The Missouri Health Facilities Review Committee has initiated review of the expedited applications listed below. A decision is tentatively scheduled for February 21, 2011. These applications are available for public inspection at the address shown below.

**Date Filed**

**Project Number:** Project Name  
City (County)  
Cost, Description

**01/10/11**

**#4610 HS:** Mineral Area Regional Medical Center  
Farmington (St. Francois County)  
\$1,740,000, Replace magnetic resonance imager

**#4611 HT:** Missouri Baptist Medical Center  
St. Louis (St. Louis County)  
\$3,253,994, Replace positron emission tomography scanner

Any person wishing to request a public hearing for the purpose of commenting on these applications must submit a written request to this effect, which must be received by February 10, 2011. All written requests and comments should be sent to—

Chairman  
Missouri Health Facilities Review Committee  
c/o Certificate of Need Program  
3418 Knipp Drive, Suite F  
Post Office Box 570  
Jefferson City, MO 65102

For additional information, contact  
Donna Schuessler, (573) 751-6403.

**T**he Secretary of State is required by sections 347.141 and 359.481, RSMo 2000, to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript by email to [dissolutions@sos.mo.gov](mailto:dissolutions@sos.mo.gov).

**NOTICE OF WINDING UP TO ALL CREDITORS OF AND CLAIMANTS  
AGAINST MR-S PROPERTIES, LLC**

On December 27, 2010, MR-S Properties, LLC, filed its Articles of Termination with the Missouri Secretary of State. The dissolution was effective on that date.

You are hereby notified that if you believe you have a claim against MR-S Properties, LLC, you must submit a summary in writing of the circumstances surrounding your claim to the company at 2014 Deer Run Court, Arnold, MO 63010. The summary of your claim must include the following information:

1. The name, address and telephone number of the claimant.
2. The amount of the claim.
3. The date on which the event on which the claim is based occurred.
4. A brief description of the nature of the debt or the basis for the claim.

All claims against MR-S Properties, LLC will be barred unless the proceeding to enforce the claim is commenced with three (3) years after the publication of this notice.

**Notice of Voluntary Dissolution  
to All Creditors of and All Claimants Against  
Sam. Wolff and Co. Incorporated**

On December 14, 2010, Sam. Wolff and Co. Incorporated, a Missouri corporation (the "Company"), filed its Articles of Dissolution by Voluntary Action with the Missouri Secretary of State.

Any claims against the Company must be sent to: James L. Fogle, 2814 S. Brentwood Blvd., St. Louis, Missouri 63144. Each claim must include the name, address and phone number of claimant; amount and nature of claim; date on which the claim arose; and any claim documentation.

All claims against the Company will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the date of publication of this notice.

**NOTICE OF DISSOLUTION TO ALL CREDITORS OF  
AND CLAIMANTS AGAINST  
RLJ GENERAL, L.C.**

On December 21, 2010, RLJ General, L.C., a Missouri limited liability company ("Company") agreed to dissolve and wind up the Company.

The Company requests that all persons and organizations who have claims against it present those claims immediately by letter to Thomas H. Mug at Gallop, Johnson and Neuman, L.C., 101 South Hanley, Suite 1700, St. Louis, Missouri 63105. All claims must include the name and address of the claimant, the amount claimed, the basis for the claim, the date(s) on which the event(s) on which the claim is based occurred, whether the claim was secured, and, if so, the collateral used as security.

NOTE: BECAUSE OF THE DISSOLUTION AND WINDING UP OF RLJ GENERAL, L.C., ANY CLAIMS AGAINST IT WILL BE BARRED UNLESS A PROCEEDING TO ENFORCE THE CLAIM IS COMMENCED WITHIN THREE (3) YEARS AFTER DECEMBER \_\_\_\_, 2010.

**NOTICE OF CORPORATE DISSOLUTION  
TO ALL CREDITORS OF AND CLAIMANTS AGAINST  
MEATEK HOLDCO, INC.**

On December 22, 2010, Meatek Holdco, Inc., a Missouri corporation, filed its Articles of Dissolution with the Missouri Secretary of State. Dissolution was effective on December 22, 2010. Said corporation requests that all persons and organizations with claims against it present them immediately by letter to the corporation in care of:

Thomas H. Bottini  
7700 Forsyth Blvd., Suite 1800,  
St. Louis, Missouri 63105-1847  
Attorney for Meatek Holdco, Inc.

All claims must include: 1) name and address of the claimant; 2) the amount claimed; 3) the basis for the claim; 4) the date(s) on which the event(s) on which the claim is based occurred; and 5) documentation of the claim.

NOTICE: BECAUSE OF THE DISSOLUTION OF MEATEK HOLDCO, INC. ANY CLAIMS AGAINST IT WILL BE BARRED UNLESS A PROCEEDING TO ENFORCE THE CLAIM IS COMMENCED WITHIN TWO YEARS AFTER THE PUBLICATION DATE OF THIS NOTICE UNDER RSMO 351.482.

**NOTICE OF DISSOLUTION OF LIMITED LIABILITY COMPANY  
TO ALL CREDITORS OF AND CLAIMANTS AGAINST  
BUSH O'DONNELL SMITH CAPITAL SERVICES, L.L.C.**

On December 29, 2010, Bush O'Donnell Smith Capital Services, L.L.C., a Missouri limited liability company (the "Company"), filed its Notice of Winding Up with the Missouri Secretary of State. The dissolution of the Company is effective December 29, 2010.

The Company requests that all persons and entities with claims against the Company present them in accordance with this notice.

All claims against the Company must be in writing and must include the name, address and telephone number of the claimant, the amount of the claim or other relief demanded, the basis of the claim, the date or dates on which the events occurred which provide a basis for the claim, and copies of any available document supporting the claim. All claims should be mailed to John W. Finger, Stinson Morrison Hecker LLP, 7700 Forsyth Boulevard, Suite 1100, St. Louis, Missouri 63105.

Any claim against the Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

**NOTICE OF DISSOLUTION OF LIMITED LIABILITY COMPANY TO ALL  
CREDITORS OF AND CLAIMS AGAINST WOODRUFF SWEITZER RETAIL, LLC**

On December 29, 2010, Woodruff Sweitzer Retail, LLC, a Missouri limited liability company, filed its Notice of Winding Up for limited liability company with the Missouri Secretary of State, effective on the filing date.

Woodruff Sweitzer Retail, LLC requests that all persons and organizations who have claims against it present them immediately by letter to Woodruff Sweitzer Retail, LLC management at 515 Cherry Street, Columbia, Missouri, 65201. All claims must include the name and address of the claimant, the amount of the claim, the basis for the claim, the date of which the claim arose, and documentation for the claim.

All claims against Woodruff Sweitzer Retail, LLC will be barred unless the proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

# Rule Changes Since Update to Code of State Regulations

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*, citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year—30 (2005) and 31 (2006). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RAN indicates a rule action notice, RUC indicates a rule under consideration, and F indicates future effective date.

Rule Number	Agency	Emergency	Proposed	Order	In Addition
1 CSR 10	<b>OFFICE OF ADMINISTRATION</b> State Officials' Salary Compensation Schedule				30 MoReg 2435 35 MoReg 1815
1 CSR 10-15.010	Commissioner of Administration	This Issue	This Issue		
1 CSR 15-3.290	Administrative Hearing Commission		35 MoReg 1381	36 MoReg 232	
1 CSR 15-3.350	Administrative Hearing Commission	35 MoReg 1367	35 MoReg 1381	36 MoReg 232	
1 CSR 15-3.380	Administrative Hearing Commission	35 MoReg 1367	35 MoReg 1382	36 MoReg 232	
1 CSR 15-3.431	Administrative Hearing Commission		35 MoReg 1382	36 MoReg 232	
1 CSR 15-3.436	Administrative Hearing Commission	35 MoReg 1368	35 MoReg 1383	36 MoReg 233	
1 CSR 15-3.446	Administrative Hearing Commission	35 MoReg 1368	35 MoReg 1383	36 MoReg 233	
1 CSR 15-3.480	Administrative Hearing Commission		35 MoReg 1384	36 MoReg 233	
1 CSR 15-3.490	Administrative Hearing Commission	35 MoReg 1369	35 MoReg 1384	36 MoReg 233	
1 CSR 15-3.500	Administrative Hearing Commission		35 MoReg 1384	36 MoReg 233	
1 CSR 15-3.560	Administrative Hearing Commission		35 MoReg 1385	36 MoReg 234	
1 CSR 20-1.010	Personnel Advisory Board and Division of Personnel	35 MoReg 1369	35 MoReg 1385	36 MoReg 234	
1 CSR 20-1.030	Personnel Advisory Board and Division of Personnel	35 MoReg 1370	35 MoReg 1386	36 MoReg 234	
1 CSR 20-2.015	Personnel Advisory Board and Division of Personnel	35 MoReg 1370	35 MoReg 1386	36 MoReg 234	
1 CSR 20-3.010	Personnel Advisory Board and Division of Personnel	35 MoReg 1371	35 MoReg 1387	36 MoReg 234	
1 CSR 20-3.020	Personnel Advisory Board and Division of Personnel	35 MoReg 1372	35 MoReg 1387	36 MoReg 235	
1 CSR 20-3.030	Personnel Advisory Board and Division of Personnel	35 MoReg 1372	35 MoReg 1388	36 MoReg 235	
1 CSR 20-3.070	Personnel Advisory Board and Division of Personnel	35 MoReg 1373	35 MoReg 1388	36 MoReg 235	
1 CSR 20-3.080	Personnel Advisory Board and Division of Personnel	35 MoReg 1374	35 MoReg 1390	36 MoReg 235	
1 CSR 20-4.010	Personnel Advisory Board and Division of Personnel	35 MoReg 1375	35 MoReg 1390	36 MoReg 236	
1 CSR 20-4.020	Personnel Advisory Board and Division of Personnel	35 MoReg 1379	35 MoReg 1394	36 MoReg 236	
1 CSR 50-3.010	Missouri Ethics Commission	35 MoReg 1379	35 MoReg 1400	This Issue	
<b>DEPARTMENT OF AGRICULTURE</b>					
2 CSR 30-1.010	Animal Health		35 MoReg 1845		
2 CSR 30-2.010	Animal Health		35 MoReg 1845		
2 CSR 30-2.020	Animal Health		35 MoReg 1846		
2 CSR 30-6.020	Animal Health		This Issue		
2 CSR 30-9.020	Animal Health	36 MoReg 217	36 MoReg 221		
2 CSR 70-11.060	Plant Industries	35 MoReg 721	35 MoReg 756 35 MoReg 1453	35 MoReg 1852	
2 CSR 80-6.041	State Milk Board		36 MoReg 224		
2 CSR 90	Weights and Measures				35 MoReg 1284
2 CSR 110-3.010	Office of the Director		35 MoReg 1848		
<b>DEPARTMENT OF CONSERVATION</b>					
3 CSR 10-4.117	Conservation Commission		35 MoReg 1533	36 MoReg 236	
3 CSR 10-5.225	Conservation Commission		35 MoReg 1533	36 MoReg 236	
3 CSR 10-5.436	Conservation Commission		35 MoReg 1534	36 MoReg 237	
3 CSR 10-5.567	Conservation Commission		35 MoReg 1534	36 MoReg 237	
3 CSR 10-6.410	Conservation Commission		35 MoReg 1534	36 MoReg 237	
3 CSR 10-6.505	Conservation Commission		35 MoReg 1400	35 MoReg 1802	
3 CSR 10-6.525	Conservation Commission		35 MoReg 1535	36 MoReg 237	
3 CSR 10-6.535	Conservation Commission		35 MoReg 1401	35 MoReg 1802	
3 CSR 10-6.605	Conservation Commission		35 MoReg 1535	36 MoReg 237	
3 CSR 10-7.410	Conservation Commission		35 MoReg 1535	36 MoReg 237	
3 CSR 10-7.431	Conservation Commission		35 MoReg 1536	36 MoReg 238	
3 CSR 10-7.432	Conservation Commission		35 MoReg 1536	36 MoReg 238	
3 CSR 10-7.438	Conservation Commission		35 MoReg 1537	36 MoReg 238	
3 CSR 10-7.445	Conservation Commission		35 MoReg 1537	36 MoReg 238	
3 CSR 10-7.455	Conservation Commission		35 MoReg 1537	36 MoReg 238	This Issue
3 CSR 10-8.510	Conservation Commission		35 MoReg 1538	36 MoReg 238	
3 CSR 10-9.105	Conservation Commission		35 MoReg 1538	36 MoReg 239	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
3 CSR 10-9.110	Conservation Commission		35 MoReg 1541	36 MoReg 239	
3 CSR 10-9.430	Conservation Commission		35 MoReg 1542	36 MoReg 239	
3 CSR 10-9.440	Conservation Commission		35 MoReg 1542	36 MoReg 239	
3 CSR 10-9.442	Conservation Commission		35 MoReg 1542	36 MoReg 239	
3 CSR 10-11.155	Conservation Commission		35 MoReg 1545	36 MoReg 239	
3 CSR 10-11.160	Conservation Commission		35 MoReg 1545	36 MoReg 240	
3 CSR 10-11.180	Conservation Commission		35 MoReg 1545	36 MoReg 240	
3 CSR 10-11.181	Conservation Commission		35 MoReg 1546	36 MoReg 240	
3 CSR 10-11.182	Conservation Commission		35 MoReg 1547	36 MoReg 240	
3 CSR 10-11.205	Conservation Commission		35 MoReg 1547	36 MoReg 240	
3 CSR 10-11.210	Conservation Commission		35 MoReg 1547	36 MoReg 240	
3 CSR 10-11.215	Conservation Commission		35 MoReg 1548	36 MoReg 241	
3 CSR 10-12.110	Conservation Commission		35 MoReg 1401	35 MoReg 1802	
3 CSR 10-12.115	Conservation Commission		35 MoReg 1402	35 MoReg 1802	
3 CSR 10-12.125	Conservation Commission		35 MoReg 1402	35 MoReg 1803	
3 CSR 10-12.140	Conservation Commission		35 MoReg 1403	35 MoReg 1803	
3 CSR 10-12.145	Conservation Commission		35 MoReg 1404	35 MoReg 1803	
3 CSR 10-12.155	Conservation Commission		35 MoReg 1405	35 MoReg 1803	
<b>DEPARTMENT OF ECONOMIC DEVELOPMENT</b>					
4 CSR 170-2.010	Missouri Housing Development Commission		35 MoReg 963R	35 MoReg 1803R	
4 CSR 170-2.100	Missouri Housing Development Commission		35 MoReg 963	35 MoReg 1803	
4 CSR 170-3.010	Missouri Housing Development Commission		35 MoReg 964R	35 MoReg 1804R	
4 CSR 170-3.100	Missouri Housing Development Commission		35 MoReg 964	35 MoReg 1804	
4 CSR 170-3.200	Missouri Housing Development Commission		35 MoReg 964	35 MoReg 1804	
4 CSR 170-4.010	Missouri Housing Development Commission		35 MoReg 965R	35 MoReg 1804R	
4 CSR 170-4.100	Missouri Housing Development Commission		35 MoReg 965	35 MoReg 1804	
4 CSR 170-4.200	Missouri Housing Development Commission		35 MoReg 966	35 MoReg 1804	
4 CSR 170-4.300	Missouri Housing Development Commission		35 MoReg 966	35 MoReg 1805	
4 CSR 170-5.010	Missouri Housing Development Commission		35 MoReg 967R	35 MoReg 1805R	
4 CSR 170-5.020	Missouri Housing Development Commission		35 MoReg 968R	35 MoReg 1805R	
4 CSR 170-5.030	Missouri Housing Development Commission		35 MoReg 968R	35 MoReg 1805R	
4 CSR 170-5.040	Missouri Housing Development Commission		35 MoReg 968R	35 MoReg 1805R	
4 CSR 170-5.050	Missouri Housing Development Commission		35 MoReg 969R	35 MoReg 1805R	
4 CSR 170-5.100	Missouri Housing Development Commission		35 MoReg 969	35 MoReg 1806	
4 CSR 170-5.200	Missouri Housing Development Commission		35 MoReg 970	35 MoReg 1806	
4 CSR 170-5.300	Missouri Housing Development Commission		35 MoReg 971	35 MoReg 1806	
4 CSR 170-5.400	Missouri Housing Development Commission		35 MoReg 971	35 MoReg 1806	
4 CSR 170-5.500	Missouri Housing Development Commission		35 MoReg 973	35 MoReg 1806	
4 CSR 170-6.010	Missouri Housing Development Commission		35 MoReg 973R	35 MoReg 1806R	
4 CSR 170-6.100	Missouri Housing Development Commission		35 MoReg 974	35 MoReg 1807	
4 CSR 170-6.200	Missouri Housing Development Commission		35 MoReg 975	35 MoReg 1807	
4 CSR 240-3.163	Public Service Commission		35 MoReg 1610		
4 CSR 240-3.164	Public Service Commission		35 MoReg 1629		
4 CSR 240-3.510	Public Service Commission		35 MoReg 1736		
4 CSR 240-20.093	Public Service Commission		35 MoReg 1647		
4 CSR 240-20.094	Public Service Commission		35 MoReg 1667		
4 CSR 240-22.010	Public Service Commission		35 MoReg 1737		
4 CSR 240-22.020	Public Service Commission		35 MoReg 1738		
4 CSR 240-22.030	Public Service Commission		35 MoReg 1741		
4 CSR 240-22.040	Public Service Commission		35 MoReg 1746		
4 CSR 240-22.045	Public Service Commission		35 MoReg 1749		
4 CSR 240-22.050	Public Service Commission		35 MoReg 1753		
4 CSR 240-22.060	Public Service Commission		35 MoReg 1761		
4 CSR 240-22.070	Public Service Commission		35 MoReg 1766		
4 CSR 240-22.080	Public Service Commission		35 MoReg 1769		
4 CSR 240-32.190	Public Service Commission		35 MoReg 1848		36 MoReg 190
4 CSR 240-123.080	Public Service Commission		35 MoReg 1686		
4 CSR 240-125.090	Public Service Commission		35 MoReg 1686		
<b>DEPARTMENT OF HIGHER EDUCATION</b>					
6 CSR 10-2.080	Commissioner of Higher Education		36 MoReg 229		
6 CSR 10-2.150	Commissioner of Higher Education		36 MoReg 230		
<b>DEPARTMENT OF TRANSPORTATION</b>					
7 CSR 10-16.010	Missouri Highways and Transportation Commission		35 MoReg 1173R	36 MoReg 241R	
7 CSR 10-16.020	Missouri Highways and Transportation Commission		35 MoReg 1173R	36 MoReg 241R	
			35 MoReg 1173	36 MoReg 241	
7 CSR 10-16.025	Missouri Highways and Transportation Commission		35 MoReg 1174	36 MoReg 242	
7 CSR 10-16.030	Missouri Highways and Transportation Commission		35 MoReg 1174R	36 MoReg 242R	
7 CSR 10-16.035	Missouri Highways and Transportation Commission		35 MoReg 1175	36 MoReg 242	
7 CSR 10-16.040	Missouri Highways and Transportation Commission		35 MoReg 1178R	36 MoReg 243R	
7 CSR 10-16.045	Missouri Highways and Transportation Commission		35 MoReg 1178	36 MoReg 243	
7 CSR 10-16.050	Missouri Highways and Transportation Commission		35 MoReg 1180	36 MoReg 244	
7 CSR 10-25.010	Missouri Highways and Transportation Commission				35 MoReg 1818 36 MoReg 190



Rule Number	Agency	Emergency	Proposed	Order	In Addition
<b>DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS</b>					
8 CSR 30-3.060	Division of Labor Standards		35 MoReg 1405	36 MoReg 245	
<b>DEPARTMENT OF MENTAL HEALTH</b>					
9 CSR 30-4.045	Certification Standards	35 MoReg 1017	35 MoReg 1022	35 MoReg 1807	
<b>DEPARTMENT OF NATURAL RESOURCES</b>					
10 CSR 10-5.330	Air Conservation Commission		36 MoReg 14		
10 CSR 10-5.340	Air Conservation Commission		36 MoReg 32		
10 CSR 10-5.442	Air Conservation Commission		36 MoReg 38		
10 CSR 10-5.455	Air Conservation Commission		36 MoReg 47		
10 CSR 10-5.480	Air Conservation Commission		35 MoReg 1080	36 MoReg 176	
10 CSR 10-6.020	Air Conservation Commission		36 MoReg 51		
10 CSR 10-6.060	Air Conservation Commission	36 MoReg 218	36 MoReg 86		This Issue
10 CSR 10-6.065	Air Conservation Commission	36 MoReg 219	36 MoReg 95		This Issue
10 CSR 10-6.070	Air Conservation Commission		35 MoReg 1091	36 MoReg 182	
10 CSR 10-6.075	Air Conservation Commission		35 MoReg 1092	36 MoReg 183	
10 CSR 10-6.080	Air Conservation Commission		35 MoReg 1094	36 MoReg 183	
10 CSR 10-6.200	Air Conservation Commission		36 MoReg 103		
10 CSR 10-6.400	Air Conservation Commission		35 MoReg 1095	36 MoReg 183	
10 CSR 20-8.110	Clean Water Commission		35 MoReg 1454		
10 CSR 23-4.010	Division of Geology and Land Survey		36 MoReg 118		
10 CSR 23-4.020	Division of Geology and Land Survey		36 MoReg 119		
10 CSR 23-4.030	Division of Geology and Land Survey		36 MoReg 120		
10 CSR 23-4.040	Division of Geology and Land Survey		36 MoReg 120R		
10 CSR 23-4.050	Division of Geology and Land Survey		36 MoReg 121		
10 CSR 23-4.060	Division of Geology and Land Survey		36 MoReg 121		
10 CSR 23-4.070	Division of Geology and Land Survey		36 MoReg 126R		
10 CSR 23-4.080	Division of Geology and Land Survey		36 MoReg 126		
10 CSR 140-2.010	Division of Energy	35 MoReg 1523	35 MoReg 1548		
10 CSR 140-2.020	Division of Energy	35 MoReg 1525	35 MoReg 1550		
10 CSR 140-2.030	Division of Energy	35 MoReg 1527R	35 MoReg 1554R		
10 CSR 140-8.010	Division of Energy		35 MoReg 1022	35 MoReg 1807	
<b>DEPARTMENT OF PUBLIC SAFETY</b>					
11 CSR 45-1.010	Missouri Gaming Commission		35 MoReg 1095	35 MoReg 1811	
11 CSR 45-1.090	Missouri Gaming Commission		35 MoReg 1246	36 MoReg 183	
11 CSR 45-4.020	Missouri Gaming Commission		35 MoReg 1247	36 MoReg 183	
11 CSR 45-5.051	Missouri Gaming Commission		35 MoReg 1249	36 MoReg 184	
11 CSR 45-5.075	Missouri Gaming Commission		35 MoReg 1250	36 MoReg 184	
11 CSR 45-5.130	Missouri Gaming Commission		35 MoReg 1780		
11 CSR 45-5.200	Missouri Gaming Commission		35 MoReg 1250	36 MoReg 184	
11 CSR 45-5.300	Missouri Gaming Commission		35 MoReg 1251	36 MoReg 184	
11 CSR 45-7.070	Missouri Gaming Commission		35 MoReg 1780		
11 CSR 45-9.102	Missouri Gaming Commission		35 MoReg 1781		
11 CSR 45-9.105	Missouri Gaming Commission		35 MoReg 1781		
11 CSR 45-9.113	Missouri Gaming Commission		35 MoReg 1096	35 MoReg 1812	
11 CSR 45-9.114	Missouri Gaming Commission		35 MoReg 1098	35 MoReg 1812	
11 CSR 45-9.118	Missouri Gaming Commission		35 MoReg 1098	35 MoReg 1812	
11 CSR 45-9.119	Missouri Gaming Commission		35 MoReg 1781		
11 CSR 45-9.121	Missouri Gaming Commission		35 MoReg 1787		
11 CSR 45-9.122	Missouri Gaming Commission		35 MoReg 1787		
11 CSR 45-12.090	Missouri Gaming Commission		36 MoReg 127		
11 CSR 45-30.020	Missouri Gaming Commission		35 MoReg 1252	35 MoReg 1852	
11 CSR 45-30.025	Missouri Gaming Commission		35 MoReg 1252	35 MoReg 1852	
11 CSR 45-30.030	Missouri Gaming Commission		35 MoReg 1253R	35 MoReg 1852R	
11 CSR 45-30.035	Missouri Gaming Commission		35 MoReg 1253	35 MoReg 1853	
11 CSR 45-30.070	Missouri Gaming Commission		35 MoReg 1254	35 MoReg 1853	
11 CSR 45-30.175	Missouri Gaming Commission		35 MoReg 1254	35 MoReg 1853	
11 CSR 45-30.190	Missouri Gaming Commission	35 MoReg 1241	35 MoReg 1254	35 MoReg 1853	
11 CSR 45-30.205	Missouri Gaming Commission		35 MoReg 1255	35 MoReg 1853	
11 CSR 45-30.210	Missouri Gaming Commission		35 MoReg 1255	35 MoReg 1853	
11 CSR 45-30.225	Missouri Gaming Commission		35 MoReg 1256	35 MoReg 1854	
11 CSR 45-30.355	Missouri Gaming Commission		35 MoReg 1256	35 MoReg 1854	
11 CSR 45-30.535	Missouri Gaming Commission		35 MoReg 1256	35 MoReg 1854	
11 CSR 45-30.540	Missouri Gaming Commission		35 MoReg 1257	35 MoReg 1854	
11 CSR 45-30.600	Missouri Gaming Commission		35 MoReg 1257	35 MoReg 1854	
<b>DEPARTMENT OF REVENUE</b>					
12 CSR 10-3.052	Director of Revenue		35 MoReg 1405R	36 MoReg 184R	
12 CSR 10-3.112	Director of Revenue		35 MoReg 1257R	35 MoReg 1855R	
12 CSR 10-3.118	Director of Revenue		35 MoReg 1258R	35 MoReg 1855R	
12 CSR 10-3.126	Director of Revenue		35 MoReg 1258R	35 MoReg 1855R	
12 CSR 10-3.130	Director of Revenue		35 MoReg 1258R	35 MoReg 1855R	
12 CSR 10-3.134	Director of Revenue		35 MoReg 1258R	35 MoReg 1855R	
12 CSR 10-3.140	Director of Revenue		35 MoReg 1259R	35 MoReg 1855R	
12 CSR 10-3.146	Director of Revenue		35 MoReg 1259R	35 MoReg 1855R	
12 CSR 10-3.192	Director of Revenue		35 MoReg 1259R	35 MoReg 1856R	
12 CSR 10-3.194	Director of Revenue		35 MoReg 1259R	35 MoReg 1856R	
12 CSR 10-3.196	Director of Revenue		35 MoReg 1260R	35 MoReg 1856R	
12 CSR 10-3.198	Director of Revenue		35 MoReg 1260R	35 MoReg 1856R	
12 CSR 10-3.204	Director of Revenue		35 MoReg 1260R	35 MoReg 1856R	
12 CSR 10-3.228	Director of Revenue		35 MoReg 1260R	35 MoReg 1856R	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
12 CSR 10-3.264	Director of Revenue		35 MoReg 1261R	35 MoReg 1856R	
12 CSR 10-3.266	Director of Revenue		35 MoReg 1261R	35 MoReg 1857R	
12 CSR 10-3.288	Director of Revenue		35 MoReg 1261R	35 MoReg 1857R	
12 CSR 10-3.330	Director of Revenue		35 MoReg 1314R	36 MoReg 184R	
12 CSR 10-3.333	Director of Revenue		35 MoReg 1314R	36 MoReg 185R	
12 CSR 10-3.350	Director of Revenue		35 MoReg 1314R	36 MoReg 185R	
12 CSR 10-3.352	Director of Revenue		35 MoReg 1315R	36 MoReg 185R	
12 CSR 10-3.354	Director of Revenue		35 MoReg 1315R	36 MoReg 185R	
12 CSR 10-3.376	Director of Revenue		35 MoReg 1315R	36 MoReg 185R	
12 CSR 10-3.382	Director of Revenue		35 MoReg 1315R	36 MoReg 185R	
12 CSR 10-3.388	Director of Revenue		35 MoReg 1316R	36 MoReg 185R	
12 CSR 10-3.406	Director of Revenue		35 MoReg 1316R	36 MoReg 186R	
12 CSR 10-3.414	Director of Revenue		35 MoReg 1316R	36 MoReg 186W	
12 CSR 10-3.426	Director of Revenue		35 MoReg 1406R	36 MoReg 186R	
12 CSR 10-3.428	Director of Revenue		35 MoReg 1406R	36 MoReg 186R	
12 CSR 10-3.431	Director of Revenue		35 MoReg 1406R	36 MoReg 186R	
12 CSR 10-3.434	Director of Revenue		35 MoReg 1406R	36 MoReg 186R	
12 CSR 10-3.436	Director of Revenue		35 MoReg 1407R	36 MoReg 187R	
12 CSR 10-3.438	Director of Revenue		35 MoReg 1407R	36 MoReg 187R	
12 CSR 10-3.443	Director of Revenue		35 MoReg 1407R	36 MoReg 187R	
12 CSR 10-3.444	Director of Revenue		35 MoReg 1408R	36 MoReg 187R	
12 CSR 10-3.446	Director of Revenue		35 MoReg 1408R	36 MoReg 187R	
12 CSR 10-3.490	Director of Revenue		35 MoReg 1408R	36 MoReg 187R	
12 CSR 10-3.496	Director of Revenue		35 MoReg 1408R	36 MoReg 188R	
12 CSR 10-3.498	Director of Revenue		35 MoReg 1476R	36 MoReg 245R	
12 CSR 10-3.504	Director of Revenue		35 MoReg 1476R	36 MoReg 245R	
12 CSR 10-3.506	Director of Revenue		35 MoReg 1476R	36 MoReg 245R	
12 CSR 10-3.522	Director of Revenue		35 MoReg 1476R	36 MoReg 245R	
12 CSR 10-3.534	Director of Revenue		35 MoReg 1477R	36 MoReg 245R	
12 CSR 10-3.536	Director of Revenue		35 MoReg 1477R	36 MoReg 245R	
12 CSR 10-3.542	Director of Revenue		35 MoReg 1477R	36 MoReg 246R	
12 CSR 10-3.556	Director of Revenue		35 MoReg 1477R	36 MoReg 246R	
12 CSR 10-3.565	Director of Revenue		35 MoReg 1478R	36 MoReg 246R	
12 CSR 10-3.585	Director of Revenue		35 MoReg 1478R	36 MoReg 246R	
12 CSR 10-3.620	Director of Revenue		35 MoReg 1478R	36 MoReg 246R	
12 CSR 10-3.626	Director of Revenue		35 MoReg 1478R	36 MoReg 246R	
12 CSR 10-3.856	Director of Revenue		35 MoReg 1479R	36 MoReg 247R	
12 CSR 10-3.862	Director of Revenue		35 MoReg 1479R	36 MoReg 247R	
12 CSR 10-3.868	Director of Revenue		35 MoReg 1687R		
12 CSR 10-3.870	Director of Revenue		35 MoReg 1479R	36 MoReg 247R	
12 CSR 10-3.884	Director of Revenue		35 MoReg 1687R		
12 CSR 10-3.886	Director of Revenue		35 MoReg 1687R		
12 CSR 10-3.896	Director of Revenue		35 MoReg 1687R		
12 CSR 10-24.305	Director of Revenue		35 MoReg 1316	36 MoReg 188	
12 CSR 10-26.020	Director of Revenue	35 MoReg 1309	35 MoReg 1317	36 MoReg 188	
12 CSR 10-41.010	Director of Revenue	35 MoReg 1735	35 MoReg 1787		
12 CSR 10-44.100	Director of Revenue		35 MoReg 1554	This Issue	
<b>DEPARTMENT OF SOCIAL SERVICES</b>					
13 CSR 30-2.010	Child Support Enforcement		35 MoReg 1688		
13 CSR 40-2.370	Family Support Division		35 MoReg 1556		
13 CSR 40-91.040	Family Support Division (Changed from 19 CSR 40-11.010)		35 MoReg 1482	This Issue	
13 CSR 70-3.110	MO HealthNet Division		36 MoReg 128R		
13 CSR 70-3.130	MO HealthNet Division		35 MoReg 1261	36 MoReg 247	
13 CSR 70-15.010	MO HealthNet Division	35 MoReg 1067	35 MoReg 1108	35 MoReg 1813	
13 CSR 70-15.110	MO HealthNet Division	35 MoReg 1070	35 MoReg 1111	35 MoReg 1813	
13 CSR 70-15.160	MO HealthNet Division	35 MoReg 1527	35 MoReg 1556		
13 CSR 70-20.320	MO HealthNet Division	35 MoReg 1072	35 MoReg 1114		
13 CSR 70-97.010	MO HealthNet Division		36 MoReg 128		
<b>ELECTED OFFICIALS</b>					
15 CSR 30-50.010	Secretary of State		35 MoReg 1479	This Issue	
15 CSR 30-51.020	Secretary of State		35 MoReg 1480	This Issue	
15 CSR 30-51.030	Secretary of State		35 MoReg 1481	This Issue	
15 CSR 30-51.173	Secretary of State		35 MoReg 1482	This Issue	
15 CSR 30-54.210	Secretary of State		36 MoReg 128		
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16 CSR 10-5.010	The Public School Retirement System of Missouri		35 MoReg 1263	35 MoReg 1857	
16 CSR 10-6.040	The Public School Retirement System of Missouri		35 MoReg 1263 36 MoReg 231	35 MoReg 1857	
16 CSR 50-2.030	The County Employees' Retirement Fund		35 MoReg 1791		
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18 CSR 10-2.010	Office of State Public Defender		35 MoReg 1180	36 MoReg 188	
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19 CSR 30-1.074	Division of Regulation and Licensure	35 MoReg 1072	35 MoReg 1116	35 MoReg 1813	
19 CSR 40-11.010	Division of Maternal, Child and Family Health ( <i>Changed to 13 CSR 40-91.040</i> )		35 MoReg 1482	This Issue	
19 CSR 60-50	Missouri Health Facilities Review Committee				36 MoReg 192 36 MoReg 248 This Issue
19 CSR 60-50.200	Missouri Health Facilities Review Committee		35 MoReg 1562		
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19 CSR 60-50.420	Missouri Health Facilities Review Committee		35 MoReg 1565		
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20 CSR 2110-2.240	Missouri Dental Board		35 MoReg 1267	35 MoReg 1858	
20 CSR 2120-2.100	State Board of Embalmers and Funeral Directors	35 MoReg 1242	35 MoReg 1267	35 MoReg 1858	
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20 CSR 2150-2.080	State Board of Registration for the Healing Arts	36 MoReg 13	36 MoReg 173		
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20 CSR 2205-5.010	Missouri Board of Occupational Therapy		35 MoReg 1271R 35 MoReg 1271	35 MoReg 1858R 35 MoReg 1858	
20 CSR 2210-2.030	State Board of Optometry		35 MoReg 1409		

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20 CSR 2220-2.005	State Board of Pharmacy	35 MoReg 1451	35 MoReg 1485		
20 CSR 2234-1.050	Board of Private Investigator Examiners		35 MoReg 1690		
20 CSR 2263-2.031	State Committee for Social Workers	35 MoReg 1310	35 MoReg 1320	36 MoReg 189	
20 CSR 2263-2.045	State Committee for Social Workers	35 MoReg 1311	35 MoReg 1320	36 MoReg 189	
20 CSR 2263-2.050	State Committee for Social Workers	35 MoReg 1312	35 MoReg 1323	36 MoReg 189	
20 CSR 2267-2.020	Office of Tattooing, Body Piercing, and Branding		35 MoReg 1849		
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1 CSR 10-15.010 Cafeteria Plan	This Issue	Jan. 1, 2011	June 29, 2011
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1 CSR 15-3.350 Complaints	.35 MoReg 1367	Sept. 9, 2010	March 7, 2011
1 CSR 15-3.380 Answers and Other Responsive Pleadings	.35 MoReg 1367	Sept. 9, 2010	March 7, 2011
1 CSR 15-3.436 Involuntary Dismissal	.35 MoReg 1368	Sept. 9, 2010	March 7, 2011
1 CSR 15-3.446 Decision on the Complaint without a Hearing	.35 MoReg 1368	Sept. 9, 2010	March 7, 2011
1 CSR 15-3.490 Hearings on Complaints; Default	.35 MoReg 1369	Sept. 9, 2010	March 7, 2011
<b>Personnel Advisory Board and Division of Personnel</b>			
1 CSR 20-1.010 General Organization	.35 MoReg 1369	Sept. 7, 2010	March 5, 2011
1 CSR 20-1.030 Personnel Rules	.35 MoReg 1370	Sept. 7, 2010	March 5, 2011
1 CSR 20-2.015 Broad Classification Bands for Managers	.35 MoReg 1370	Sept. 7, 2010	March 5, 2011
1 CSR 20-3.010 Examinations	.35 MoReg 1371	Sept. 7, 2010	March 5, 2011
1 CSR 20-3.020 Registers	.35 MoReg 1372	Sept. 7, 2010	March 5, 2011
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1 CSR 20-4.010 Appeals	.35 MoReg 1375	Sept. 7, 2010	March 5, 2011
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1 CSR 50-3.010 Late Fee	.35 MoReg 1379	Sept. 9, 2010	March 7, 2011
<b>Department of Agriculture</b>			
<b>Animal Health</b>			
2 CSR 30-9.020 Animal Care Facility Rules Governing Licensing, Fees Reports, Record Keeping, Veterinary Care, Identification and Holding Period	.36 MoReg 217	Dec. 17, 2010	June 14, 2011
<b>Department of Mental Health</b>			
<b>Certification Standards</b>			
9 CSR 30-4.045 Intensive Community Psychiatric Rehabilitation	.35 MoReg 1017	July 1, 2010	Feb. 24, 2011
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<b>Air Conservation Commission</b>			
10 CSR 10-6.060 Construction Permits Required	.36 MoReg 218	Jan. 3, 2011	July 1, 2011
10 CSR 10-6.065 Operating Permits	.36 MoReg 219	Jan. 3, 2011	July 1, 2011
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10 CSR 140-2.010 Definitions	.35 MoReg 1523	Oct. 10, 2010	April 7, 2011
10 CSR 140-2.020 General Provisions	.35 MoReg 1525	Oct. 10, 2010	April 7, 2011
10 CSR 140-2.030 Public Sector Eligibility	.35 MoReg 1527	Oct. 10, 2010	April 7, 2011
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<b>Missouri Gaming Commission</b>			
11 CSR 45-30.190 Rules of Play	.35 MoReg 1241	Aug. 28, 2010	Feb. 23, 2011
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<b>Director of Revenue</b>			
12 CSR 10-26.020 License Requirements for Auctions, Dealers, Franchisors, and Manufacturers	.35 MoReg 1309	Aug. 28, 2010	Feb. 24, 2011
12 CSR 10-41.010 Annual Adjusted Rate of Interest	.35 MoReg 1735	Jan. 1, 2011	June 29, 2011
<b>Department of Social Services</b>			
<b>MO HealthNet Division</b>			
13 CSR 70-15.160 Prospective Outpatient Hospital Services Reimbursement Methodology	.35 MoReg 1527	Oct. 1, 2010	March 29, 2011

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19 CSR 30-1.074 Dispensing Without a Prescription . . . . .	35 MoReg 1072 . . . . .	Sept. 28, 2010 . . . . .	March 26, 2011
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20 CSR 2030-6.015 Application, Renewal, Reinstatement, Relicensure, and Miscellaneous Fees . . . . .	35 MoReg 1242 . . . . .	July 30, 2010 . . . . .	Feb. 24, 2011
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20 CSR 2063-1.010 Definitions . . . . .	36 MoReg 5 . . . . .	Dec. 10, 2010 . . . . .	June 7, 2011
20 CSR 2063-1.015 Fees . . . . .	36 MoReg 6 . . . . .	Dec. 10, 2010 . . . . .	June 7, 2011
20 CSR 2063-2.005 Application for Licensure . . . . .	36 MoReg 7 . . . . .	Dec. 10, 2010 . . . . .	June 7, 2011
20 CSR 2063-2.015 Notification of Change of Address . . . . .	36 MoReg 8 . . . . .	Dec. 10, 2010 . . . . .	June 7, 2011
20 CSR 2063-3.005 Certifying Entities . . . . .	36 MoReg 9 . . . . .	Dec. 10, 2010 . . . . .	June 7, 2011
20 CSR 2063-4.005 Education and Training Requirements . . . . .	36 MoReg 10 . . . . .	Dec. 10, 2010 . . . . .	June 7, 2011
20 CSR 2063-5.005 Supervision of Assistant Behavior Analysts . . . . .	36 MoReg 11 . . . . .	Dec. 10, 2010 . . . . .	June 7, 2011
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20 CSR 2120-2.100 Fees . . . . .	35 MoReg 1242 . . . . .	Aug. 5, 2010 . . . . .	Feb. 24, 2011
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20 CSR 2150-2.080 Fees . . . . .	36 MoReg 13 . . . . .	Nov. 29, 2010 . . . . .	May 27, 2011
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20 CSR 2200-4.010 Fees . . . . .	Next Issue . . . . .	Jan. 14, 2011 . . . . .	July 12, 2011
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20 CSR 2220-2.005 Definitions . . . . .	35 MoReg 1451 . . . . .	Sept. 13, 2010 . . . . .	March 11, 2011
<b>State Committee for Social Workers</b>			
20 CSR 2263-2.031 Acceptable Supervisors and Supervisor Responsibilities . . . . .	35 MoReg 1310 . . . . .	Aug. 28, 2010 . . . . .	Feb. 24, 2011
20 CSR 2263-2.045 Provisional Licenses . . . . .	35 MoReg 1311 . . . . .	Aug. 28, 2010 . . . . .	Feb. 24, 2011
20 CSR 2263-2.050 Application for Licensure as a Social Worker . . . . .	35 MoReg 1312 . . . . .	Aug. 28, 2010 . . . . .	Feb. 24, 2011
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22 CSR 10-2.020 General Membership Provisions . . . . .	This Issue . . . . .	Jan. 1, 2011 . . . . .	June 29, 2011
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22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges . . . . .	This Issue . . . . .	Jan. 1, 2011 . . . . .	June 29, 2011
22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges . . . . .	This Issue . . . . .	Jan. 1, 2011 . . . . .	June 29, 2011
22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges . . . . .	This Issue . . . . .	Jan. 1, 2011 . . . . .	June 29, 2011
22 CSR 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges . . . . .	This Issue . . . . .	Jan. 1, 2011 . . . . .	June 29, 2011
22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges . . . . .	This Issue . . . . .	Jan. 1, 2011 . . . . .	June 29, 2011
22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan, and HDHP Limitations . . . . .	This Issue . . . . .	Jan. 1, 2011 . . . . .	June 29, 2011
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22 CSR 10-2.090 Pharmacy Benefit Summary . . . . .	This Issue . . . . .	Jan. 1, 2011 . . . . .	June 29, 2011
22 CSR 10-2.091 Wellness Program Coverage, Provisions and Limitations . . . . .	This Issue . . . . .	Jan. 1, 2011 . . . . .	June 29, 2011
22 CSR 10-2.092 Dental Benefit Summary . . . . .	This Issue . . . . .	Jan. 1, 2011 . . . . .	June 29, 2011
22 CSR 10-2.093 Vision Benefit Summary . . . . .	This Issue . . . . .	Jan. 1, 2011 . . . . .	June 29, 2011
22 CSR 10-3.010 Definitions . . . . .	This Issue . . . . .	Jan. 1, 2011 . . . . .	June 29, 2011
22 CSR 10-3.045 Plan Utilization Review Policy . . . . .	This Issue . . . . .	Jan. 1, 2011 . . . . .	June 29, 2011
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22 CSR 10-3.051 PPO 300 Plan Benefit Provisions and Covered Charges . . . . .	This Issue . . . . .	Jan. 1, 2011 . . . . .	June 29, 2011
22 CSR 10-3.052 PPO 500 Plan Benefit Provisions and Covered Charges . . . . .	This Issue . . . . .	Jan. 1, 2011 . . . . .	June 29, 2011
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22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges . . . . .	This Issue . . . . .	Jan. 1, 2011 . . . . .	June 29, 2011
22 CSR 10-3.060 PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP Plan Limitations . . . . .	This Issue . . . . .	Jan. 1, 2011 . . . . .	June 29, 2011
22 CSR 10-3.075 Review and Appeals Procedure . . . . .	This Issue . . . . .	Jan. 20, 2011 . . . . .	June 29, 2011

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<b>22 CSR 10-3.090</b>	Pharmacy Benefit Summary . . . . .	.This Issue . . . . .	Jan. 1, 2011 . . . . .	June 29, 2011
<b>22 CSR 10-3.092</b>	Dental Benefit Summary . . . . .	.This Issue . . . . .	Jan. 1, 2011 . . . . .	June 29, 2011
<b>22 CSR 10-3.093</b>	Vision Benefit Summary . . . . .	.This Issue . . . . .	Jan. 1, 2011 . . . . .	June 29, 2011

<b>Executive Orders</b>	<b>Subject Matter</b>	<b>Filed Date</b>	<b>Publication</b>
<b>2011</b>			
<b>11-01</b>	Gives the Director of the Department of Natural Resources the authority to temporarily suspend regulations in the aftermath of severe winter weather that began on December 30	Jan. 4, 2011	Next Issue
<b>2010</b>			
<b>10-27</b>	Declares a state of emergency and directs the Missouri State Emergency Operations Plan be activated due to severe weather that began on December 30	Dec. 31, 2010	This Issue
<b>Emergency Declaration</b>	Proclaims an emergency declaration concerning the damage and structural integrity of the State Route A bridge over the Weldon Fork of the Thompson River	Sept. 28, 2010	35 MoReg 1531
<b>10-26</b>	Designates members of the governor's staff to have supervisory authority over certain departments, divisions, and agencies	Sept. 24, 2010	35 MoReg 1529
<b>10-25</b>	Extends the declaration of emergency contained in Executive Order 10-22 for the purpose of protecting the safety and welfare of our fellow Missourians	July 20, 2010	35 MoReg 1244
<b>10-24</b>	Creates the Code of Fair Practices for the Executive Branch of State Government and supersedes paragraph one of Executive Order 05-30	July 9, 2010	35 MoReg 1167
<b>Emergency Declaration</b>	Proclaims that an emergency exists concerning the damage and structural integrity of the U.S. Route 24 bridge over the Grand River	July 2, 2010	35 MoReg 1165
<b>10-23</b>	Activates the state militia in response to severe weather that began on June 12	June 23, 2010	35 MoReg 1078
<b>10-22</b>	Declares a state of emergency and directs the Missouri State Emergency Operations Plan be activated due to severe weather that began on June 12	June 21, 2010	35 MoReg 1076
<b>10-21</b>	Activates the Missouri State Emergency Operations Center	June 15, 2010	35 MoReg 1018
<b>10-20</b>	Establishes the Missouri Civil War Sesquicentennial Commission	April 2, 2010	35 MoReg 754
<b>10-19</b>	Amends Executive Order 09-17 to give the commissioner of the Office of Administration supervisory authority over the Transform Missouri Project	March 2, 2010	35 MoReg 637
<b>10-18</b>	Establishes the Children in Nature Challenge to challenge Missouri communities to take action to enhance children's education about nature, and to increase children's opportunities to personally experience nature and the outdoors	Feb. 26, 2010	35 MoReg 573
<b>10-17</b>	Establishes a Missouri Emancipation Day Commission to promote, consider, and recommend appropriate activities for the annual recognition and celebration of Emancipation Day	Feb. 2, 2010	35 MoReg 525
<b>10-16</b>	Transfers the scholarship portion of the A+ Schools Program from the Missouri Department of Elementary and Secondary Education to the Missouri Department of Higher Education	Jan. 29, 2010	35 MoReg 447
<b>10-15</b>	Transfers the Breath Alcohol Program from the Missouri Department of Transportation to the Missouri Department of Health and Senior Services	Jan. 29, 2010	35 MoReg 445
<b>10-14</b>	Designates members of the governor's staff to have supervisory authority over certain departments, divisions, and agencies	Jan. 29, 2010	35 MoReg 443
<b>10-13</b>	Directs the Department of Social Services to disband the Missouri Task Force on Youth Aging Out of Foster Care	Jan. 15, 2010	35 MoReg 364
<b>10-12</b>	Rescinds Executive Orders 98-14, 95-21, 95-17, and 94-19 and terminates the Governor's Commission on Driving While Intoxicated and Impaired Driving	Jan. 15, 2010	35 MoReg 363
<b>10-11</b>	Rescinds Executive Order 05-41 and terminates the Governor's Advisory Council for Veterans Affairs and assigns its duties to the Missouri Veterans Commission	Jan. 15, 2010	35 MoReg 362
<b>10-10</b>	Rescinds Executive Order 01-08 and terminates the Personal Independence Commission and assigns its duties to the Governor's Council on Disability	Jan. 15, 2010	35 MoReg 361
<b>10-09</b>	Rescinds Executive Orders 95-10, 96-11, and 98-13 and terminates the Governor's Council on AIDS and transfers their duties to the Statewide HIV/STD Prevention Community Planning Group within the Department of Health and Senior Services	Jan. 15, 2010	35 MoReg 360
<b>10-08</b>	Rescinds Executive Order 04-07 and terminates the Missouri Commission on Patient Safety	Jan. 15, 2010	35 MoReg 358
<b>10-07</b>	Rescinds Executive Order 01-16 and terminates the Missouri Commission on Intergovernmental Cooperation	Jan. 15, 2010	35 MoReg 357
<b>10-06</b>	Rescinds Executive Order 05-13 and terminates the Governor's Advisory Council on Plant Biotechnology and assigns its duties to the Missouri Technology Corporation	Jan. 15, 2010	35 MoReg 356



**Executive**

<b>Orders</b>	<b>Subject Matter</b>	<b>Filed Date</b>	<b>Publication</b>
<b>10-05</b>	Rescinds Executive Order 95-28 and terminates the Missouri Board of Geographic Names	Jan. 15, 2010	35 MoReg 355
<b>10-04</b>	Rescinds Executive Order 03-10 and terminates the Missouri Energy Policy Council	Jan. 15, 2010	35 MoReg 354
<b>10-03</b>	Rescinds Executive Order 03-01 and terminates the Missouri Lewis and Clark Bicentennial Commission	Jan. 15, 2010	35 MoReg 353
<b>10-02</b>	Rescinds Executive Order 07-29 and terminates the Governor's Advisory Council on Aging and assigns its duties to the State Board of Senior Services	Jan. 15, 2010	35 MoReg 352
<b>10-01</b>	Rescinds Executive Order 01-15 and terminates the Missouri Commission on Total Compensation	Jan. 15, 2010	35 MoReg 351

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## ADMINISTRATION, OFFICE OF

### Administrative Hearing Commission

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Leave room in your chapters for expansion of rules. Normally rule numbers should be assigned in increments of ten (10)–15 CSR 30-997.010, 15 CSR 30-997.020, etc. This way, you should have room to add rules between numbers in the future should the need to do so arise.

For more about rule numbering please see page 5.02A of *Rulemaking 1-2-3 Drafting and Style Manual* which can be found online at <http://www.sos.mo.gov/adrules/manual/manual.asp>.